## Patient Support Program

### Support for patients who are prescribed INGREZZA® (valbenazine) capsules

The **INBRACE® Support Program** is designed to help patients who are prescribed INGREZZA. From reimbursement verification and financial assistance to prescription fulfillment and product support, the program assists your patients and their caregivers—so they can focus on treatment goals.

Savings Program

**Eligible patients may qualify for a $0 copay on their INGREZZA prescription***

*This offer is valid only for patients who have commercial (nongovernment-funded) insurance. Additional terms and conditions apply.

For more information about the INGREZZA Savings Program, visit **https://sservices.trialcard.com/Coupon/ingrezza**

## INGREZZA Start Program

### INGREZZA free trial (one-month supply) is available for new patients

This program is not contingent on a purchase of any kind. Product dispensed under this free trial program may not be submitted for reimbursement to any third-party payer. We reserve the right to modify or cancel the program at any time.

---

**For patients without insurance coverage for INGREZZA**

Eligible patients who do not have prescription coverage for INGREZZA and lack the financial resources to pay for their medicine may be able to receive their prescription at no cost through the INGREZZA Patient Assistance Program.

**For additional information and resources, visit www.INBRACEsupportprogram.com or call 84-INGREZZA (844-647-3992), 8 AM to 8 PM ET, Monday through Friday.**

**Please see full Important Safety Information on page 4 and accompanying full Prescribing Information.**

# The Prescription Process for INGREZZA® (valbenazine) capsules

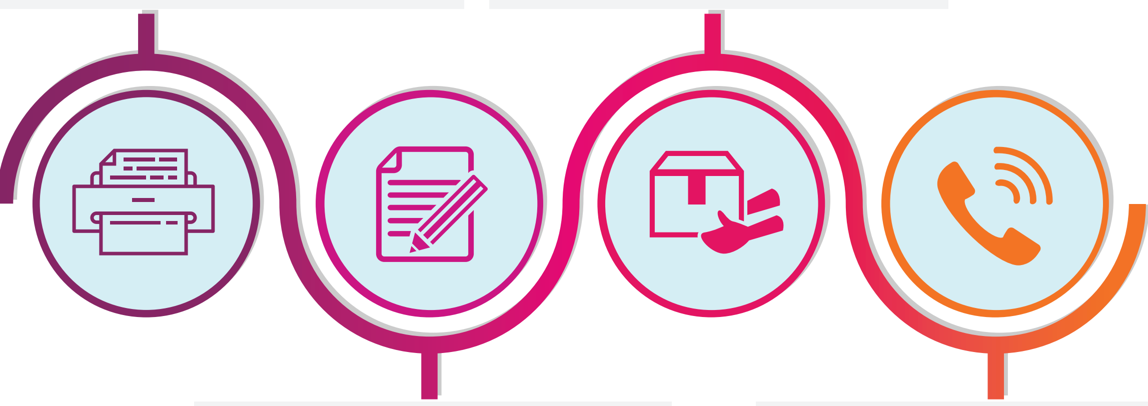
### Enrollment

Here are the simple steps to prescribe INGREZZA and enroll your patients in the INBRACE Support Program:

- Download the Treatment Form* at www.INBRACEsupportprogram.com
- Submit completed form via fax (**844-394-7155**) to the INBRACE Support Program

### Delivery

A specialty pharmacy will arrange next-day shipping of the INGREZZA prescription directly to your patient, at a location of their choosing.



### Benefit Verification

The specialty pharmacy selected will perform the benefit investigations and help you navigate the prior authorization process.

### Follow-up

Patients will receive monthly calls from a specialty pharmacy to refill their prescriptions.

## INGREZZA Is Available Through Specialty Pharmacies

Neurocrine Biosciences has contracted with a select network of specialty pharmacies that will help ensure timely delivery of INGREZZA directly to your patients.†

**Specialty Pharmacy Providers for INGREZZA**

| Amber Pharmacy | Orsini Healthcare | PANTHER$_x$® Specialty Pharmacy |
|---|---|---|
| www.amberpharmacy.com<br>Phone: 888-370-1724<br>Fax: 402-896-3774 | www.orsinihealthcare.com<br>Phone: 800-279-1676<br>Fax: 877-868-1681 | www.pantherspecialty.com<br>Phone: 844-221-3777<br>Fax: 844-364-6394 |
| Hours of operation:<br>7:00 AM to 7:00 PM (CT), Monday-Friday<br>8:00 AM to 2:00 PM (CT), Saturday<br>Pharmacist on-call 24/7 | Hours of operation:<br>8:30 AM to 5:00 PM (CT), Monday-Friday<br>Pharmacist on-call 24/7 | Hours of operation:<br>8:00 AM to 8:00 PM (EST), Monday-Friday<br>Pharmacist on-call 24/7 |

*On page 3, you will find a sample annotated treatment form to reference when you submit the form to the INBRACE Support Program.

†You can ePrescribe to the specialty pharmacies listed above, or your Neurocrine Representative may be able to provide you with other pharmacies that have access to INGREZZA.

**Please see full Important Safety Information on page 4 and accompanying full Prescribing Information.**

## The INGREZZA® (valbenazine) capsules Treatment Form

Our simple process starts with the INGREZZA Treatment Form, which both enrolls patients into the INBRACE® Support Program and serves as their prescription for INGREZZA. The sample Treatment Form below has been pre-populated to help provide guidance for when you submit the form to the INBRACE Support Program.

INGREZZA® (valbenazine) capsules | Treatment Form

INBRACE® Support that surrounds you with care.

For additional assistance, call 84-INGREZZA (844-647-3992), 8 AM–8 PM ET, M–F.

INSTRUCTIONS: Please complete and fax this page to 844-394-7155.

Enter patient information

Check applicable boxes, sign, and date (patient)

### 1 PATIENT INFORMATION

First Name: | Last Name: | DOB: / /

Address: | City: | State: | ZIP:

Last 4 digits of the SSN: | US Resident: ☐ Yes ☐ No | Gender: ☐ Male ☐ Female

Preferred Phone: | Mobile Phone? ☐ Yes ☐ No | Email:

Alternate Contact/Caregiver: | Alternate Contact/Caregiver Phone:

(Optional) Ship Prescription to: ☐ Caregiver ☐ HCP office

Patient Signature: | Date:

☐ **I consent to have my prescription shipped to preference above.**

**By signing here, I authorize the use and disclosure of my Protected Health Information as explained on page 3.**

☐ **I have read and agree to the INBRACE Program Opt-In as explained on page 3.**

Enter member ID number

### 2 PATIENT INSURANCE INFORMATION–Please attach a copy of the patient's insurance card. (Check below if no insurance)

☐ Patient does not have insurance. | **Medical Insurance Name:** | **Prescription Insurance Name:**

Phone: | Cardholder ID #: | Phone: | Cardholder ID #:

Policyholder Name & DOB: / / | BIN: | PCN:

Enter diagnosis and clinical information

### 3 CLINICAL INFORMATION

Primary Diagnosis Code Category: ☐ **Tardive Dyskinesia (G24.01)** | ☐ Other diagnosis: | Allergies:

Enter prescription information

### 4 PRESCRIPTION FOR INGREZZA CAPSULES

**PRESCRIPTION INSTRUCTIONS:** Check **Initial Rx, Maintenance Rx** or BOTH. If in-office samples were used, there is no need to check the **Initial Rx** box.

☐ **Initial Rx**
40 mg once daily x 7 days
80 mg once daily x 23 days
1-month supply
**No refills**

☐ **Maintenance Rx**
80 mg once daily
1-month supply
**Maintenance Rx Refills #**________

OR

☐ Other Rx:
Sig: ________________
Quantity: ________________
Other Rx Refills: ________________

Preferred Pharmacy if applicable: ☐ Amber Pharmacy ☐ Orsini Healthcare ☐ PANTHERx® Specialty Pharmacy ☐ No Preference

Enter prescriber information

### 5 PRESCRIBER INFORMATION

Prescriber Name: | Prescriber NPI #:

Facility Name: | Provider Phone:

Address: | City: | State: | ZIP:

Office Contact Name: | Phone: | Fax: | Email:

INGREZZA Start Program information and selection

### 6 INGREZZA START PROGRAM (OPTIONAL)

**Free Trial Program Rx (New Patients)**

I authorize the INBRACE Program Pharmacy to dispense a free one-time 1-month supply of INGREZZA. This program is only available to adults diagnosed with tardive dyskinesia and is not contingent on a purchase of any kind. Product dispensed under this free trial program may not be submitted for reimbursement to any third party payer. We reserve the right to modify or cancel the program at any time.

Select one of the following (**NO REFILLS**):

☐ 40 mg once a day x 7 days and 80 mg once a day x 21 days ***OR***

☐ 40 mg once a day x 30 days ***OR***

☐ Other Rx:
Sig: ____________ Quantity: ____________

Sign and date (prescriber)

### 7 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Treatment Form is complete and accurate to the best of my knowledge, I have prescribed INGREZZA based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of Neurocrine Biosciences, Inc. (including, but not limited to INGREZZA dispensing pharmacies) for benefits eligibility, coverage authorization and coordination and dispensing of INGREZZA. I authorize the forwarding of this prescription and information to a dispensing specialty pharmacy. I understand that neither I nor the patient should seek reimbursement for any free or discounted product received under the program. If the patient has requested shipment to my office, I agree not to receive any compensation for dispensing the product and I will clearly label and dispense only for use by the patient.

Prescriber Signature: | Date:

*(Original signature required - *If required by applicable law, please attach copies of all prescriptions on official state prescription forms)*

**Please see Indication and Important Safety Information on page 2.**

©2018 Neurocrine Biosciences, Inc. All Rights Reserved. CP-VBZ-US-0252v4 09/18

Neurocrine BIOSCIENCES

**For additional information, visit www.INBRACEsupportprogram.com or call 84-INGREZZA (844-647-3992), 8 AM to 8 PM ET, Monday through Friday.**

**Please see full Important Safety Information on page 4 and accompanying full Prescribing Information.**

## Important Information

### Indication & Usage

INGREZZA® (valbenazine) capsules is indicated for the treatment of adults with tardive dyskinesia.

## IMPORTANT SAFETY INFORMATION

### CONTRAINDICATIONS

INGREZZA is contraindicated in patients with a history of hypersensitivity to valbenazine or any components of INGREZZA. Rash, urticaria, and reactions consistent with angioedema (e.g., swelling of the face, lips, and mouth) have been reported.

### WARNINGS & PRECAUTIONS

#### Somnolence

INGREZZA can cause somnolence. Patients should not perform activities requiring mental alertness such as operating a motor vehicle or operating hazardous machinery until they know how they will be affected by INGREZZA.

#### QT Prolongation

INGREZZA may prolong the QT interval, although the degree of QT prolongation is not clinically significant at concentrations expected with recommended dosing. INGREZZA should be avoided in patients with congenital long QT syndrome or with arrhythmias associated with a prolonged QT interval. For patients at increased risk of a prolonged QT interval, assess the QT interval before increasing the dosage.

### ADVERSE REACTIONS

The most common adverse reaction (≥5% and twice the rate of placebo) is somnolence. Other adverse reactions (≥2% and >placebo) include: anticholinergic effects, balance disorders/falls, headache, akathisia, vomiting, nausea, and arthralgia.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit MedWatch at www.fda.gov/medwatch or call 1-800-FDA-1088.

**Please see attached INGREZZA full Prescribing Information or visit www.INGREZZAHCP.com**

©2018 Neurocrine Biosciences, Inc. All Rights Reserved. CP-VBZ-US-0392v4 09/18