INGREZZA® (valbenazine) capsules | Start Program Form

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

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

1 PATIENT INFORMATION

First Name:

Last Name: DOB: / /

Address:

Address (cont):

City: State: ZIP:

US Resident: ☐ Yes ☐ No Gender: ☐ Male ☐ Female

Email:

Preferred Phone:

Mobile Phone? ☐ Yes ☐ No

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

I consent to have my Rx shipped to the preference noted above and for the INBRACE Program Pharmacy to contact the Caregiver listed below.

Patient Signature: Date:

Alternate Contact/Caregiver:

Alt Contact/Caregiver Phone:

2 PRESCRIBER INFORMATION

Prescriber Name:

Prescriber NPI #:

Facility Name:

Address:

City: State: ZIP:

Phone:

Fax:

Office Contact Name:

Office Contact Phone:

Office Contact Fax:

Office Contact Email:

3 DIAGNOSIS CODE

☐ **Tardive Dyskinesia (G24.01)**

4 INGREZZA START PROGRAM

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: _____

5 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Start Program 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 coordination and dispensing of INGREZZA. I authorize the forwarding of this prescription and information to a dispensing pharmacy for the INGREZZA Start Program. 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 back of form.

INBRACE® Support that surrounds you with care.

Neurocrine BIOSCIENCES

INGREZZA® (valbenazine) capsules | Start Program Form

INBRACE®
Support that surrounds you with care.

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 accompanying INGREZZA full Prescribing Information or visit www.INGREZZAHCP.com

Neurocrine BIOSCIENCES

INGREZZA® (valbenazine) capsules