INGREZZA® (valbenazine) capsules | INGREZZA® SPRINKLE (valbenazine) capsules

Service Request Form

INBRACE® SUPPORT PROGRAM

INSTRUCTIONS

To be completed in full, signed, and dated, then faxed to 1-844-394-7155.
For additional assistance, call 1-84-INGREZZA (1-844-647-3992), 8 AM – 8 PM ET, M – F.

Completion of this form does not initiate treatment but is intended to request access and reimbursement services. Do not submit prescription.
Please complete and fax the Service Request Form to 1-844-394-7155.

***Indicates required field.**

1 STATEMENT OF SERVICES

To be completed by prescribing physician, nurse, or facility pharmacist

***Please select the services needed (check all that apply):** ☐ **Perform a benefits investigation** ☐ **Prior authorization or appeals support**

2 RESIDENT/PATIENT INFORMATION

***Name** _____ Gender

***DOB (MM/DD/YYYY)** ***Zip code**

Phone number

***Facility/Office point of contact:**

***Name**

***Phone number** Email

INSURANCE INFORMATION

Section required if resident/patient has insurance
A copy of resident's face sheet can be provided instead of completing this section.

☐ Resident/patient does not have insurance
☐ Resident's face sheet provided
☐ Please check if resident has secondary insurance and a copy of card with completed form

***Prescription drug plan** ***Phone number**

***Member ID** Plan number

Cardholder name Group number

Relationship to cardholder BIN PCN

Medicare beneficiary ID number Last 4 digits of SSN

Resident/Patient/Authorized Representative Signature Date:

By signing here, I authorize the use and disclosure of my PHI as set forth in the HIPAA Authorization on page 2.

Description of Authorized Representative's Authority:

***Resides at:** ☐ **Skilled nursing facility/nursing home** ☐ **Assisted living** ☐ **Not a long-term care resident (If your patient is not a resident, skip to section 3)**

***Facility name** ***Facility address**

Facility email ***City** ***State** ***Zip** ***Facility phone number** ***Facility fax number**

Preferred time and day to be contacted ***Pharmacy name** ***Pharmacy phone #** Pharmacy fax #

☐ Check if your facility/pharmacy uses CoverMyMeds®

☐ Check this box if your resident is currently covered under Medicare Part A; expected discharge date: _____

3 CLINICAL INFORMATION

***Primary diagnosis (ICD-10 code):** ☐ **Tardive dyskinesia (G24.01)** ☐ **Huntington's chorea (G10)** ☐ **Other diagnosis (ICD-10 code)**

4 PRESCRIPTION FOR INGREZZA (valbenazine) CAPSULES OR INGREZZA® SPRINKLE (valbenazine) CAPSULES

PRESCRIPTION INSTRUCTIONS*:

1. Select ONE of the following INGREZZA formulations:

☐ INGREZZA ☐ INGREZZA SPRINKLE

2. Check ONE box within initial Rx and ONE box within Maintenance Rx*

INITIAL Rx*

☐ 40 mg once daily x 7 then 80 mg once daily x 21 (Tardive dyskinesia)
☐ 40 mg once daily × 14 then 60 mg once daily × 14 (Huntington's chorea)
No refills

MAINTENANCE Rx*

☐ 40 mg once daily, 1-month supply
☐ 60 mg once daily, 1-month supply
☐ 80 mg once daily, 1-month supply **Refills #** _____

☐ **Other Rx** Sig: Quantity: Other Rx Refills:

*If in-office samples were used, you may select Maintenance Rx only.

Prescriber Authorization: I certify that the information provided in this Service Request Form is complete and accurate to the best of my knowledge, any prescribing decisions are based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I certify that, where required by federal and/or state law, I have obtained my patient's written legal permission to share identifiable information with Neurocrine Biosciences, Inc., and its agents and pharmacies, including but not limited to the INBRACE Support Program. I direct the INBRACE Support Program to convey, on my behalf, any treatment information about INGREZZA to the patient's health insurance company, to the dispensing pharmacy chosen by or for the patient, or to other third parties as may be necessary to assist this patient with securing any insurance coverage for INGREZZA to which the patient is entitled or with filling a prescription for INGREZZA.

Prescriber or authorized agent name: _____ ***Prescriber NPI:**

Prescriber phone number: _____ Prescriber fax number: _____

*Prescriber or Authorized Representative Signature ***Date:**

(Original signature required.)

PATIENT HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Neurocrine, companies working with Neurocrine, my healthcare provider and pharmacy to use and disclose to Neurocrine, and companies working with Neurocrine, my Protected Health Information ("PHI"), such as information provided on the INGREZZA Service Request Form, my prescription, insurance, medical therapy information and other PHI for the following purposes: (1) providing financial assistance options, (2) reimbursement support, (3) medication compliance and persistence, (4) information about Neurocrine products and programs, which may from time to time include requests to participate in market research or other initiatives related to my experiences with my condition and/or INGREZZA, and (5) other treatment-related services, including providing information and materials related to the INBRACE Support Program (collectively called "Support Services"). I authorize the disclosure of my PHI to communicate with the point of contact in Section 2 of the Service Request Form. I understand that the companies working with Neurocrine, including my pharmacy, may receive payment for the use and disclosure of my PHI. I understand that once it is disclosed, it may be re-disclosed by the recipient(s). After such a disclosure, the information may no longer be protected by HIPAA or the terms of this authorization against further re-disclosure. I understand that this authorization shall continue in effect for a period of ten years unless a shorter period is required by law. I understand that I may revoke this authorization to use or disclose my PHI by contacting an INBRACE Support Program representative by telephone (1-844-647-3992) or by mailing a letter to Neurocrine, Attn: INBRACE Support Program, 12780 El Camino Real, San Diego, CA 92130. I understand that my healthcare provider, pharmacy, and/or Neurocrine will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization. However, if I choose not to sign, Neurocrine will not be able to help me with Support Services as described above. I may obtain a copy of this Authorization upon request.

For the Neurocrine Biosciences, Inc. Privacy Policy, please visit www.neurocrine.com/about-us/privacy-policy/