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

PATIENT ASSISTANCE PROGRAM

INBRACE® SUPPORT PROGRAM

INSTRUCTIONS

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

- Only completed INGREZZA Patient Assistance Program Applications will be reviewed for patient program eligibility. Please ensure all areas of the form are completed in full with all signatures.
- Applicants must reside in the US or its territories, meet the program financial requirements, and must not have prescription coverage for INGREZZA in order to qualify. Each applicant will be assessed for individual program eligibility upon receipt of this completed INGREZZA Patient Assistance Program Application. Other terms may apply.

1 PATIENT INFORMATION

First Name*: | Last Name*: | Date of Birth*: ☐☐/☐☐/☐☐☐☐

Address: | City: | State: | ZIP:

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

Preferred Phone: | Is Preferred Phone a mobile number? ☐ Yes ☐ No | Email:

Alternate Contact/Care Partner: | Alternative Contact/Care Partner Phone:

Patient/Authorized Representative Signature: Date:

Description of Authorized Representative's Authority:

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

(Optional) I consent to have my prescription shipped to:
☐ Care Partner ☐ HCP Office
☐ LTC ☐ Group Home

Patient Residence:
☐ At Home ☐ LTC
☐ Group Home ☐ Other

2 PATIENT INSURANCE INFORMATION—Please attach a copy of the patient's insurance card (check below if no insurance)

Medical Insurance Name: | **Prescription Insurance Name:**

Cardholder ID #: | Cardholder ID #:

Policy Holder Name: | BIN#: | PCN#:

Phone: | Policy Holder DOB: / / | Rx Group #: | Phone:

Payer Type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other ☐ Patient Does Not Have Insurance

For insured patients, a denied PA and denied Appeal are required.

3 FINANCIAL INFORMATION—If information is unavailable, INBRACE Support Program specialists will contact the patient

Total Monthly Gross Household Income: $ | Number of People Living in Household: (If living in a group home, enter 1)

☐ Patient has indicated unaffordable cost share. Cost share amount $

4 CLINICAL INFORMATION

Primary Diagnosis Code Category*: ☐ Tardive dyskinesia (G24.01) ☐ Huntington's chorea (G10) ☐ Other diagnosis: | Allergies:

5 PRESCRIBER INFORMATION

Prescriber Name*: | Prescriber NPI*:

Office/Facility:

Address: | City: | State: | ZIP:

Phone: | Fax:

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

Referring Pharmacy Name: | Address: | Phone:

6 PRESCRIPTION FOR INGREZZA (valbenazine) CAPSULES OR INGREZZA SPRINKLE (valbenazine) CAPSULES

PRESCRIPTION INSTRUCTIONS*:

1. Select ONE of the following INGREZZA formulations:

☐ INGREZZA capsules

☐ INGREZZA SPRINKLE capsules

2. Check ONE box within initial Rx and/or ONE box within Maintenance Rx* *If in-office samples were used, you may select Maintenance Rx only.

Initial Rx	Maintenance Rx*
☐ 40 mg once daily x 7 then 80 mg once daily x 21 (Tardive dyskinesia)	☐ 40 mg once daily, 1-month supply
☐ 40 mg once daily x 14 then 60 mg once daily x 14 (Huntington's chorea)	☐ 60 mg once daily, 1-month supply
No refills.	☐ 80 mg once daily, 1-month supply **Refills #** ☐☐

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

7 PRESCRIBER CERTIFICATION

I certify that the information provided in this Patient Assistance Program (the "PAP") Application 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, where required by law, I have obtained my patient's written legal permission to share identifiable information with Neurocrine Biosciences, Inc. and the INBRACE Support Program Pharmacy. I authorize the forwarding of this prescription and information to the INBRACE Support Program Pharmacy. I understand that neither I nor the patient, LTC facility, or pharmacy may seek reimbursement for any free or discounted product received under the PAP. Patients are not eligible for the PAP if their insurance plan or employer participates in an alternate funding program (also sometimes referred to as patient advocacy program, alternative access program, or specialty network) requiring the patient to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant Neurocrine products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program. Patients also are not eligible if such a plan or program changes or hides the patient's insurance coverage to make the patient appear to be underinsured and eligible for the PAP. The PAP requires the healthcare provider or facility to retain proof of patient income on file in their office. For the purposes of an audit, the PAP may ask for a copy of the patient's IRS 1040 form or other proof of income. I agree to notify the PAP if I become aware at any time in the future of changes in my patient's circumstances that would affect eligibility, including but not limited to changes in health insurance status or coverage, financial status, or United States residency status. I understand that Neurocrine Biosciences, Inc. reserves the right to change or terminate the PAP at any time.

Prescriber Signature:* | Date*:

*Indicates required fields.

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

NEUROCRINE® BIOSCIENCES

PATIENT HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Neurocrine, companies working with Neurocrine, and my healthcare provider, pharmacy, and insurer to use and disclose to Neurocrine, and companies working with Neurocrine, my Protected Health Information ("PHI"), such as information provided on this 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 healthcare experiences, and (5) other treatment-related services, including providing information and materials related to the INBRACE Support Program (collectively called "Support Services"). I understand that the companies working with Neurocrine, including my pharmacy, may receive payment related to the use and disclosure of my PHI which could be considered marketing under HIPAA, in which case I hereby provide my authorization for such arrangement. I understand that once my PHI is disclosed to Neurocrine or companies working with Neurocrine it will no longer be protected by HIPAA and may be subject to redisclosure by the recipient. I understand that this authorization shall continue in effect for a period of ten years, unless a one-year period is required by law. I understand that I may revoke this authorization by contacting an INBRACE Support Program representative by telephone (844-647-3992) or by mailing a letter to Neurocrine, Attn: INBRACE Support Program, 200 Industry Dr, Suite 100, Pittsburgh, PA 15275. I understand that cancelling this authorization will not affect any use or disclosure of my PHI that has already taken place in reliance on this authorization. I understand that I am not required to sign this authorization and that my healthcare providers will not otherwise condition my treatment, payment, health insurance enrollment, or eligibility for health care benefits to which I am otherwise entitled on whether I 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 more on how Neurocrine uses your information, please visit www.neurocrine.com/privacy-policy.