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

TREATMENT FORM

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.

1 PATIENT INFORMATION

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

Address: | City: | State: | ZIP:

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

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

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

Patient Residence: ☐ At Home ☐ LTC ☐ Group Home ☐ Other | **(Optional) I consent to have my prescription shipped to:** ☐ Care Partner ☐ HCP Office

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:

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—please fill out the PAP application instead of this form

3 CLINICAL INFORMATION

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

4 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 the 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: ☐

Preferred Pharmacy if applicable: ☐ Amber Specialty Pharmacy ☐ CVS Specialty Pharmacy ☐ Orsini Specialty Pharmacy ☐ Walgreens Specialty Pharmacy[b] ☐ PANTHERx Rare ☐ No preference

[b]If a prescription is sent to a local Walgreens Specialty Pharmacy, please contact the pharmacy directly.

OR

Local pharmacy with access to INGREZZA: ☐ Pharmacy Name: _____ Pharmacy NPI: _____ Pharmacy Fax: _____

Pharmacy Phone: _____ Pharmacy Address: _____

5 PRESCRIBER INFORMATION

Prescriber Name*: | Prescriber NPI*:

Office/Facility: | Phone: | Fax:

Address: | City: | State: | ZIP:

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

6 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules or INGREZZA® SPRINKLE (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, 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., its agents, and pharmacies, including but not limited to the INBRACE Support Program Pharmacy and the pharmacies listed in Section 4 above. I authorize the forwarding of this prescription and information to a dispensing specialty pharmacy. If the patient has requested shipment to my office, LTC facility, or pharmacy, 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*:

*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