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.

1 PATIENT INFORMATION

First Name:	Last Name:		DOB: / /
Address:	City:	State:	ZIP:
Preferred Phone:	Mobile Phone? ☐ Yes ☐ No	Gender: ☐ Male	☐ Female
Alternate Phone:	Email:	Last 4 digits of the SSN:	
Alternate Contact/Caregiver:	Alternate Contact/Caregiver Phone:		

(Optional) I consent to have my prescription shipped to: ☐ Caregiver ☐ HCP office

Patient Signature: Date:

By signing above, 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.**

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:

3 CLINICAL INFORMATION

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

4 PRESCRIPTION FOR INGREZZA (valbenazine) CAPSULES

PRESCRIPTION INSTRUCTIONS: Check one Rx box below.

Initial Rx with 80 mg Maintenance Rx

☐ **INGREZZA Initial Rx**
40 mg once daily x 7 days then
80 mg once daily x 23 days
No refills

INGREZZA Maintenance Rx
80 mg once daily
1-month supply
Refills # _____

OR

Initial Rx with 40 mg Maintenance Rx

☐ **INGREZZA 40 mg**
40 mg once daily
1-month supply
Refills # _____

OR

80 mg Maintenance Rx Only*

☐ **INGREZZA 80 mg**
80 mg once daily
1-month supply
Refills # _____

*If 40 mg in-office samples were used, you may choose to select 80 mg Maintenance Rx Only.

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

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

5 PRESCRIBER INFORMATION

Prescriber Name:			Prescriber NPI #:
Facility Name:			Provider Phone:
Address:	City:	State:	ZIP:
Office Contact Name:	Phone:	Fax:	Email:

6 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. 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.

Neurocrine BIOSCIENCES

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.

Parkinsonism

INGREZZA may cause parkinsonism in patients with tardive dyskinesia. Parkinsonism has also been observed with other VMAT2 inhibitors. Reduce the dose or discontinue INGREZZA treatment in patients who develop clinically significant parkinson-like signs or symptoms.

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/PI

PATIENT SERVICES/OTHER COMMUNICATIONS

Patient Authorization

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 Treatment Form, my prescription, insurance, medical therapy information and other PHI in connection with the Support Services as described below. I authorize the disclosure of my PHI to specific individuals who are identified on the INGREZZA Treatment 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 I do not have to agree to the use and disclosure of my PHI in order to receive INGREZZA, but without this authorization I may not be able to receive the Support Services. While my PHI will be protected and used and disclosed only for the intended purposes, 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 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 (844-647-3992) or by mailing a letter to Neurocrine, Attn: INBRACE Support Program, 12780 El Camino Real, San Diego, CA 92130.

Program Opt-In

I authorize Neurocrine, and companies working with Neurocrine, to provide me with support services related to Neurocrine products, marketing materials, information about Neurocrine products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics. Services may also include, but are not limited to: online support, financial assistance services, reimbursement support, medication compliance and persistence, and other treatment related services, as well as any information or materials related to such services (collectively called "Support Services"). I agree and acknowledge that any nurse or other person providing Support Services is not employed by my healthcare professional. I authorize Neurocrine, and companies working with Neurocrine, to contact me to provide Support Services and information by mail, e-mail, fax, telephone call, text message, and other means. I understand that I do not have to agree to receive the Support Services and that I can still receive INGREZZA, as prescribed by my physician. I understand that I am under no obligation to purchase INGREZZA, whether or not I have started INGREZZA under a free trial program offered by Neurocrine. I understand that I cannot seek reimbursement from any health insurance or third party, including state or federally funded programs, for free trial product nor can it be counted towards my true out-of-pocket costs. I certify that I am at least eighteen (18) years of age. I understand that I may opt-out of receiving the Support Services by notifying an INBRACE Support Program representative by telephone (844-647-3992) or by mailing a letter to Neurocrine, Attn: INBRACE Support Program, 12780 El Camino Real, San Diego, CA 92130.