INGREZZA® (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 EST, M – F.

1 PATIENT INFORMATION

First Name*:	Last Name*:	Last 4 digits of the SSN:	Date of Birth*: / /
Address:	City:	State:	ZIP:
Preferred Phone:	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 3.	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

3 CLINICAL INFORMATION

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

4 PRESCRIPTION FOR INGREZZA (valbenazine) CAPSULES

PRESCRIPTION INSTRUCTIONS*: Check <u>one</u> Rx box below.

☐ **Initial Rx with 80 mg Maintenance Rx**
40 mg once daily x 7 then
80 mg once daily x 23
No refills.
80 mg once daily
1-month supply. **Refills #____**

OR

☐ **Initial Rx with 40 mg Maintenance Rx**
40 mg once daily
1-month supply. **Refills #____**

OR

☐ **60 mg Maintenance Rx Only[a]**
60 mg once daily
1-month supply. **Refills #____**

OR

☐ **80 mg Maintenance Rx Only[a]**
80 mg once daily
1-month supply. **Refills #____**

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

[a]If 40 mg in-office samples were used, you may choose to select 60 mg or 80 mg Maintenance Rx Only.

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

[[b]A treatment form is not required if a prescription is sent to a Walgreens Community-Based Specialty Pharmacy – please contact the store directly.]

5 PRESCRIBER INFORMATION

Prescriber Name*:		Prescriber NPI*:	
Facility Name:		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 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 or Authorized Agent Signature:*	Date*:

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

*Indicates required fields.

NEUROCRINE® BIOSCIENCES

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 Treatment 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 Tardive Dyskinesia 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 Alternate Contact/Care Partner listed in Section 1 of the 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 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 (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/