

Service Request Form

Long-Term Care

Completion of this form does not initiate treatment but is intended to request access and reimbursement services.

See Indication and Important Safety Information, including **Boxed WARNING**, on page 2. Please read the accompanying full Prescribing Information, also available at NUPLAZIDhcp.com.

Phone: 1-844-737-2223
 Fax: 1-844-737-2224
 Long-term care: 1-877-889-0739

Please complete and fax the Service Request Form to **1-844-737-2224**, email to acadiacconnect@lashgroup.com or complete the online form at acadiacconnect.com. Please note that email communications sent to Acadia or its third-party service providers may not be encrypted or secured, and safeguards established under the HIPAA Security Rule would not apply to these communications.

1 SERVICES NEEDED

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

*Indicates required field.

*Please select the Acadia Connect[™] services needed (check all that apply):

- Perform a benefits investigation Prior authorization or appeals support Provide your resident with financial assistance options

2 RESIDENT INFORMATION/INSURANCE

A copy of the resident's prescription drug plan insurance card can be provided instead of completing the insurance section below.

*Resident name _____			Section required if resident has insurance <input type="checkbox"/> Resident does not have insurance	
*Facility name _____	*DOB (MM/DD/YYYY) _____	Gender _____	*Prescription drug plan _____	*Phone number _____
*Resident/Caregiver email _____	Resident phone number _____		*ID number _____	Plan number _____
Caregiver name _____	Caregiver phone number _____		Cardholder name _____	Group number _____
*Preferred contact: <input type="checkbox"/> Resident <input type="checkbox"/> Caregiver	Preferred language (if not English) _____		Relationship to cardholder _____	PCN/BIN number _____
			Medicare Beneficiary ID number _____	

*Resides at:

Skilled nursing facility/nursing home *Primary facility contact _____ *Job title _____ *Address _____

Assisted living *Facility name _____ *Facility phone number _____ *City _____ *State _____ *ZIP _____

Pharmacy name _____ Pharmacy phone number _____

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

3 TREATMENT INFORMATION/PRESCRIBER AUTHORIZATION

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

*Please confirm diagnosis: *Please confirm dose:

Hallucinations and delusions associated with Parkinson's disease psychosis (PDP) 34 mg capsule

Other diagnosis: _____ Other: _____

Prescriber Authorization: I attest that I have obtained written permission, in the event it is required under applicable federal and/or state law, of my patient (or the patient's legal representative) for the release of my patient's Protected Health Information ("PHI") to Acadia Pharmaceuticals Inc. or its representatives or agents (collectively "Acadia") as may be necessary for the patient's participation in a program designed to assist patients in determining their insurance coverage for NUPLAZID that I have elected to prescribe. I direct Acadia to convey, on my behalf, any prescription information delivered to Acadia for NUPLAZID to the dispensing pharmacy chosen by or for the patient, to the patient's health insurance company, or to other third parties as may be necessary to assist this patient with filling his/her prescription for NUPLAZID, with securing any insurance coverage for NUPLAZID to which the patient is entitled, or other third parties to assist with patient assistance or reduced-cost medication. I understand I am to comply with the state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. I agree that Acadia may contact me for additional information relating to NUPLAZID, including but not limited to via email, fax, and telephone. I authorize Acadia to transmit the above prescription to the pharmacy.

 *Prescriber or authorized agent name *Prescriber NPI number Prescriber phone number

)) _____
 *Prescriber or authorized agent (e.g., nurse) signature (no stamp allowed): *Date: _____

If you do not have a HIPAA authorization on file for this resident, please have them review and sign the HIPAA authorization section on page 2 of this Service Request Form.

HIPAA AUTHORIZATION Please read before signing.

I hereby authorize and direct my health care providers (including physicians, providers of long-term care, and pharmacies) and health insurance companies, and each of their respective representatives, employees, staff, and agents (collectively "Providers") to disclose my Protected Health Information ("PHI") to Acadia Pharmaceuticals Inc. and its representatives and agents (collectively "Acadia") for obtaining Acadia Connect support services. I understand that this PHI may include, but is not limited to, my name, address, phone number, and other contact information; information relating to my medical condition, treatment, care management, and health insurance; as well as information provided on this Form and any prescription. I understand that pharmacies may receive remuneration (payment) from Acadia for providing patient support services and disclosing associated PHI to Acadia pursuant to this Form.

I authorize Acadia to use and further disclose the PHI it receives as a result of this Form for:

- Providing reimbursement support associated with the filling of my prescription, including verification of my insurance benefits and assistance in securing coverage to which I am entitled.
- Facilitating the provision of patient assistance, reduced-cost medication, co-pay assistance, and/or other product-related services offered by Acadia, patient advocacy organizations, or other third parties.
- Sending me communications related to the Acadia Connect support services.
- Administrative purposes related to the above services.
- Following de-identification, use for research purposes.

» Resident/legal guardian signature: _____ Date: _____

AUTHORIZED REPRESENTATIVE CONSENT (optional)

I further authorize the Program to discuss my treatment with the following authorized representative(s):

Authorized representative (1) name (please print): _____ Relationship to patient: _____

Authorized representative (2) name (please print): _____ Relationship to patient: _____

» Resident/legal guardian signature: _____ Date: _____

Important Safety Information and Indication

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

- **Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.**
- **NUPLAZID is not approved for the treatment of patients with dementia-related psychosis unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis.**
- **Contraindication:** NUPLAZID is contraindicated in patients with a history of a hypersensitivity reaction to pimavanserin or any of its components. Rash, urticaria, and reactions consistent with angioedema (e.g., tongue swelling, circumoral edema, throat tightness, and dyspnea) have been reported.
- **Warnings and Precautions:** QT Interval Prolongation
 - NUPLAZID prolongs the QT interval. The use of NUPLAZID should be avoided in patients with known QT prolongation or in combination with other drugs known to prolong QT interval including Class 1A antiarrhythmics or Class 3 antiarrhythmics, certain antipsychotic medications, and certain antibiotics.
 - NUPLAZID should also be avoided in patients with a history of cardiac arrhythmias, as well as other circumstances that may increase the risk of the occurrence of torsade de pointes and/or sudden death, including symptomatic bradycardia, hypokalemia or hypomagnesemia, and presence of congenital prolongation of the QT interval.

I authorize Acadia to contact me using the contact information I have provided on this Form for the above purposes. I also authorize Acadia to report back to my Providers any PHI about me that Acadia may create or receive.

I understand that once my PHI is disclosed to Acadia pursuant to this Form, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) and may be subject to re-disclosure.

I understand that I may refuse to sign this Form and my refusal will not affect the treatment I receive from my Providers, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. I also understand that I may cancel (revoke) this authorization at any time by mailing a letter requesting such cancellation to the address below; however, this cancellation will not apply to any PHI already used or disclosed in reliance on this Form before notice of the cancellation is received by my Providers.

I understand that this authorization is valid for a period of 10 years or for a shorter period dictated by applicable state law. I understand that I will be provided with a signed copy of this authorization by the Provider who collects it from me.

Further information concerning Acadia's privacy practices can be found at <https://www.acadia-pharm.com/privacy>. If you are a resident of California, a description of the personal information collected by Acadia and your rights under the California Consumer Privacy Act can be found at this address.

Address to Opt Out of Communications or to Cancel This Form:
Acadia Connect, PO Box 220305, Charlotte, NC 28222

- **Adverse Reactions:** The common adverse reactions ($\geq 2\%$ for NUPLAZID and greater than placebo) were peripheral edema (7% vs 2%), nausea (7% vs 4%), confusional state (6% vs 3%), hallucination (5% vs 3%), constipation (4% vs 3%), and gait disturbance (2% vs $<1\%$).

• Drug Interactions:

- Coadministration with strong CYP3A4 inhibitors (e.g., ketoconazole) increases NUPLAZID exposure. Reduce NUPLAZID dose to 10 mg taken orally as one tablet once daily.
- Coadministration with strong or moderate CYP3A4 inducers reduces NUPLAZID exposure. Avoid concomitant use of strong or moderate CYP3A4 inducers with NUPLAZID.

Indication

NUPLAZID is indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis.

Dosage and Administration

Recommended dose: 34 mg capsule taken orally once daily, without titration.

NUPLAZID is available as 34 mg capsules and 10 mg tablets.

Please read the accompanying full [Prescribing Information](#), including **Boxed WARNING**, also available at NUPLAZIDhcp.com.