NEUROCRINE™ Access Support

# 30-DAY FREE TRIAL FORM

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

**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 4 digits of the SSN:

Last Name*: | DOB*: ___/___/___

Address:

City: | State: | ZIP:

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

US Resident: ☐ Yes ☐ No | Gender: ☐ Male ☐ Female

Email:

Preferred Phone:

Is Preferred Phone a mobile number? ☐ Yes ☐ No

Ship Prescription to (optional): ☐ Care Partner ☐ HCP Office ☐ LTC Facility

**I consent to have my Rx shipped to the preference noted and for the Neurocrine Access Support Program Pharmacy to contact the Care Partner or healthcare provider.**

## 2 PRESCRIBER INFORMATION

Prescriber Name*:

Prescriber NPI*:

Facility Name:

Address:

City: | State: | ZIP:

Phone:

Fax:

Office/Facility Contact Name:

Office/Facility Contact Phone:

Office/Facility Contact Fax:

Office/Facility Contact Email:

**Patient/Authorized Representative Signature:** | Date:

Description of Authorized Representative's Authority:

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

## 3 LTC/SNF/ASSISTED LIVING RESIDENTS† ONLY:

Resident Room Number: | Ship Prescription to: ☐ Facility Contact ☐ Facility Pharmacy

Facility Pharmacy Name: | Facility Pharmacy Phone:

Facility Pharmacy Address: | City: | State: | ZIP:

†Residents currently covered under Medicare Part A stay are not eligible.

## 4 CLINICAL INFORMATION

☐ Tardive dyskinesia (G24.01) ☐ Huntington's chorea (G10) ☐ Other diagnosis: | Allergies:

## 5 INGREZZA 30-DAY FREE TRIAL*

### Free Trial Program Rx (New Patients)

This program is only available to adults diagnosed with tardive dyskinesia or Huntington's chorea and is not contingent on a purchase of any kind. Product dispensed under this free trial program may not be submitted for reimbursement to any third-party payer. Neurocrine reserves the right to modify or cancel the program at any time. I authorize the Neurocrine Access Support Program Pharmacy to dispense a free 1-time, 1-month supply of INGREZZA or INGREZZA SPRINKLE.

### Administration Information:

INGREZZA can be taken with or without food. INGREZZA SPRINKLE may be opened and sprinkled over soft food (do not use milk or drinking water). INGREZZA SPRINKLE may be swallowed whole with water. Do not crush or chew.

**Select ONE of the following INGREZZA formulations:**

☐ INGREZZA capsules

☐ INGREZZA SPRINKLE capsules

Select one of the following dosing options **(NO REFILLS)**:

☐ 40 mg once a day x 7 days then 80 mg once a day x 21 days ***OR***

☐ 40 mg once a day x 14 days then 60 mg once a day x 14 days ***OR***

☐ 40 mg once a day x 30 days

☐ Other Rx

Sig: _____ Quantity: _____

## 6 PRESCRIBER CERTIFICATION

I certify that the information provided in this 30-Day Free Trial 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 Neurocrine Access Support Program Pharmacy. I authorize the forwarding of this prescription and information to a dispensing pharmacy for the 30-Day Free Trial Program. I understand that neither I nor the patient should seek reimbursement for any free or discounted product received under the program. 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*:

***(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, 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 Neurocrine Access 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 Neurocrine Access Support Program representative by telephone (844-647-3992) or by mailing a letter to Neurocrine, Attn: Neurocrine Access 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.**