INGREZZA® (valbenazine) capsules

PATIENT ASSISTANCE PROGRAM

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.

- Only completed INGREZZA Patient Assistance Program Applications will be reviewed for patient program eligibility. Please ensure all areas of the form are completed in full with all signatures.
- Applicants must reside in the US or its territories, meet the program financial requirements, and must not have prescription coverage for INGREZZA in order to qualify. Each applicant will be assessed for individual program eligibility upon receipt of this completed INGREZZA Patient Assistance Program Application.

1 PATIENT INFORMATION

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

Address: | City: | State: | ZIP:

Last 4 Digits of the SSN: | US Resident: ☐ Yes ☐ No | Gender: ☐ Male ☐ Female

Preferred Phone: | Is Preferred Phone a Mobile Number? ☐ Yes ☐ No | Email:

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

Patient/Authorized Representative Signature: Date:

Description of Authorized Representative's Authority:

By signing here, I authorize the use and disclosure of my PHI as set forth in the HIPAA Authorization on page 3.

(Optional) I consent to have my prescription shipped to:
☐ Care Partner ☐ HCP Office
☐ LTC ☐ Group Home

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

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

For insured patients a denied PA and denied Appeal are required.

3 FINANCIAL INFORMATION–If information is unavailable, INBRACE program specialists will contact the patient

Total Monthly Gross Household Income: $ | Number of People Living in Household:

Select Your Sources of Income: Salary/Wages ☐ SS Pension/Unemployment ☐ Alimony/Child Support ☐ Retirement ☐ SSDI ☐ SSI ☐

No Household Income ☐ Other ☐: _____

Income subject to verification.

4 CLINICAL INFORMATION

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

5 PRESCRIBER INFORMATION

Prescriber Name*: | Prescriber NPI*:

Facility Name:

Address: | City: | State: | ZIP:

Phone: | Fax:

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

Referring Pharmacy Name: | Address: | Phone:

6 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.

7 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Patient Assistance Program (the "PAP") Application 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 law, I have obtained my patient's written legal permission to share identifiable information with Neurocrine Biosciences, Inc. and the INBRACE Support Program Pharmacy. I authorize the forwarding of this prescription and information to the INBRACE Support Program Pharmacy. I understand that neither I nor the patient, LTC facility, or pharmacy may seek reimbursement for any free or discounted product received under the PAP. Patients are not eligible for the PAP if their insurance plan or employer participates in an alternate funding program (also sometimes referred to as patient advocacy program, alternative access program, or specialty network) requiring the patient to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant Neurocrine products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program. Patients also are not eligible if such plan or program changes or hides the patient's insurance coverage to make the patient appear to be underinsured and eligible for the PAP. The PAP requires the healthcare provider or facility to retain proof of patient income on file in their office. For purposes of an audit, the PAP may ask for a copy of the patient's IRS 1040 form or other proof of income. I agree to notify the PAP if I become aware at any time in the future of changes in my patient's circumstances that would affect eligibility, including but not limited to changes in health insurance status or coverage, financial status, or United States residency status. I understand that Neurocrine Biosciences, Inc. reserves the right to change or terminate the PAP at any time.

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, and my healthcare provider and pharmacy to use and disclose to Neurocrine, and companies working with Neurocrine, my Protected Health Information ("PHI"), for the following purposes (1) providing financial assistance options, (2) reimbursement support, (3) medication compliance and persistence, and (4) other treatment-related services, including providing information and materials related to such services (collectively called "Support Services"). I authorize the disclosure of my PHI to specific individuals who are identified on the INGREZZA Patient Assistance Program Application. 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 redisclosure. 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.