acadia connect®

Patient & Caregiver Support

Enrollment Form

Here for you. Here with you.

If a healthcare provider has prescribed medication from Acadia Pharmaceuticals to you or someone you care for, our support program can be an essential partner in navigating insurance, managing costs, and guiding you to useful resources.

Please complete this form to enroll and submit by email to nuplazid@acadiaconnect.com, fax 1-844-737-2224, or mail to PO Box 15713, Pittsburgh, PA 15244. If you need additional assistance, please contact us at 1-844-737-2223, Monday–Friday, 8:00 am–8:00 pm ET.

See Indication and Important Safety Information, including **Boxed WARNING**, on page 3.
Please read the full Prescribing Information, also available at NUPLAZIDhcp.com.

1 Patient Information *Tell us about yourself.*

First name ____________ Last name ____________ DOB (MM/DD/YYYY) ____________

Address ____________ Phone number (Mobile preferred) ____________

City ____________ State ______ ZIP ______ Email ____________

2 Diagnosis Information *Why were you prescribed this medication?*

☐ Hallucinations and delusions associated with Parkinson's disease psychosis (PDP)

☐ Other ____________

3 Caregiver Information *(if applicable) Who else can speak on your behalf?*

First name ____________ Last name ____________

Email ____________ Phone number (Mobile preferred) ____________

4 Insurance Information *Tell us about your insurance.*

Prescription drug plan ____________ Payer phone number ____________

Cardholder name ____________ Plan ID number ____________ Medicare ID number ____________

5 Prescriber Information *Who prescribed this medication?*

Name ____________ Phone number ____________

Please remember to read and sign the HIPAA authorization on page 2.

PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize and direct my healthcare providers (including physicians, prescribers, providers of long-term care, and pharmacies) and health insurance companies, and each of their respective representatives, employees, staff, and agents (collectively "Providers") to use my Protected Health Information ("PHI") and/or disclose it to Acadia Pharmaceuticals Inc. and its representatives and agents (collectively "Acadia") to assist with my obtaining NUPLAZID and Acadia Connect Support Services (we refer to Acadia Connect and the Acadia Copay Card Program collectively as "Acadia Connect Support Services" or the "Program"). 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 authorization 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 authorization.

I further authorize Acadia to use health information it collects about me, and to disclose it to third parties, including, but not limited to, specialty pharmacies, health plans, insurance companies, and patient assistance programs in relation to my obtaining NUPLAZID and/or participating in the Program, including communicating with me about the Program; investigating insurance benefits, eligibility, and coverage; providing financial assistance for copay or out-of-pocket payments; assessing eligibility for free medication supply; coordinating care; and coordinating the delivery of medication. I also authorize Acadia to disclose to my Providers for Program purposes any information about me that Acadia may create or receive.

I understand that once my PHI or other information about me is disclosed to or by Acadia pursuant to this authorization, it may no longer be protected by state and federal privacy laws and may be subject to re-disclosure. I understand that I may refuse to sign this authorization, 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. However, if I refuse to sign this authorization, I will not be able to participate in the Program, as the disclosures of my PHI and other information about me by my Providers and Acadia for Program purposes are necessary to facilitate my participation in the Program. I also understand that I may cancel (revoke) this authorization at any time by calling 844-737-2223 or by mailing Acadia Connect, PO Box 15713, Pittsburgh, PA 15244; however, this cancellation will not apply to any PHI or other information already used or disclosed in reliance on this authorization before notice of the cancellation is received. 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 have a right to receive and will be provided with a signed copy of this authorization by Acadia. I may request additional copies by contacting Acadia by calling 844-737-2223 or by mailing Acadia Connect, PO Box 15713, Pittsburgh, PA 15244.

» **Sign Here* Patient/Parent/Legal Guardian: ______________________ *Date ____________

Name: ______________________ Relationship to Patient: ______________________

PROGRAM SIGN-UP & CONSENT TO PROCESS HEALTH INFO FOR PROGRAM PURPOSES (Required to participate in the Program)

I agree to enroll in Acadia Connect and, if I am eligible, I agree to enroll in the Acadia Copay Card Program. I understand that any assistance with my cost-sharing or co-payment for NUPLAZID will be made in accordance with the Program Terms and Conditions at https://www.acadiaconnect.com/nuplazid/patient-caregivers.

I also agree that Acadia may collect and process health information about me, including the details I provided on this form, information about my participation in the Program, and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same, to facilitate my participation in the Program, including to investigate insurance benefits, eligibility, and coverage; provide financial assistance for copay or out-of-pocket payments; eligibility for free medication supply; coordinating care; coordinating the delivery of medication. I also agree that Acadia may contact me at the contact information I have provided on this form, including by calling or emailing me, for purposes related to my participation in the Program.

I understand that I am not required to consent to this processing of my health information. However, if I do not consent, I will not be able to participate in the Program, as processing of my health information is necessary for Acadia to facilitate my participation in the Program. If I withdraw my consent, my participation in the program will end.

If I consent, I have the right to withdraw my consent at any time by calling 844-737-2223 or mailing Acadia Connect, PO Box 15713, Pittsburgh, PA 15244. For more information about Acadia's privacy practices, go to www.acadia.com/privacy. For additional privacy disclosures for California residents, go to https://acadia.com/privacy/#california.

☐ I consent

CONSENT TO RECEIVE TEXTS (Optional)

I agree that Acadia may contact me via text message at the above phone number regarding the Program and other Acadia products and services. I confirm that I am the subscriber for the mobile telephone number(s) I provided on this form, and I agree to notify Acadia promptly by calling 844-737-2223 or by mailing Acadia Connect, PO Box 15713, Pittsburgh, PA 15244 if any of my numbers change in the future. I understand that my wireless service provider's message and data rates may apply. I can opt out of future communications by responding STOP to any text. I UNDERSTAND THAT THESE COMMUNICATIONS MAY USE PRERECORDED/ARTIFICIAL VOICE MESSAGES AND/OR AN AUTOMATED SYSTEM AND THAT I DO NOT NEED TO AGREE TO RECEIVE CALLS OR TEXTS AS A CONDITION OF PURCHASING OR RECEIVING ANY GOODS OR SERVICES FROM ACADIA.

☐ I consent

☐ I do not consent

AUTHORIZATION TO DISCLOSE INFORMATION TO INDIVIDUALS INVOLVED IN MY CARE (Optional)

I further authorize Acadia to discuss the coordination of my care with the family member(s) and/or caregiver(s) I list below. These individual(s) have my full permission to obtain and disclose personal and medical information about me from Acadia.

Authorized Representative(s) (please print): ______________________________

Name: ______________________________ Relationship to Patient: ______________________________

❯❯ **Sign Here* Patient/Parent/Legal Guardian: ______________________________ *Date ____________

Indication

NUPLAZID is a prescription medicine used to treat hallucinations and delusions associated with Parkinson's disease psychosis.

Important Safety Information

WARNING: INCREASED RISK OF DEATH IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

- **Medicines like NUPLAZID can raise the risk of death in elderly people who have lost touch with reality (psychosis) due to confusion and memory loss (dementia).**
- **NUPLAZID is not approved for the treatment of patients with dementia who experience psychosis unless their hallucinations and delusions are related to Parkinson's disease.**

- **Do not take NUPLAZID if you** have had an allergic reaction to any of the ingredients in NUPLAZID. Allergic reactions have included rash, hives, swelling of the tongue, mouth, lips, or face, throat tightness, and shortness of breath.
- **NUPLAZID may cause serious side effects including:**
  - **QT Interval Prolongation:** NUPLAZID may increase the risk of changes to your heart rhythm. This risk may increase if NUPLAZID is taken with certain other medications known to prolong the QT interval. Tell your healthcare provider about all the medicines you take or have recently taken.
  - **Do not take NUPLAZID if you have certain heart conditions** that change your heart rhythm. It is important to talk to your healthcare provider about this possible side effect. Call your healthcare provider if you feel a change in your heartbeat.
- **Tell your healthcare provider about all the medicines you take.** Other medicines may affect how NUPLAZID works. Some medicines should not be taken with NUPLAZID. Your healthcare provider can tell you if it is safe to take NUPLAZID with your other medicines. Do not start or stop any medicines while taking NUPLAZID without talking to your healthcare provider first.
- The **common side effects** of NUPLAZID include swelling in the legs or arms, nausea, confusion, hallucination, constipation, and changes to normal walking. These are not all the possible side effects of NUPLAZID. For more information, ask your healthcare provider about this medicine.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088. You can also call ACADIA Pharmaceuticals Inc. at 1-844-4ACADIA (1-844-422-2342).

Dosage and Administration

The recommended dose of NUPLAZID is one 34 mg capsule once per day, taken by mouth, with or without food.

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

Please read the full Prescribing Information, including **Boxed WARNING**, also available at NUPLAZID.com.

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ONCE-DAILY NUPLAZID® (pimavanserin) 34mg capsules