

Enrollment Form

Here for you. Here with you.

acadia
connect[®]

Patient & Care Partner Support

This support program connects you and/or your care partner with educational support and resources before and after NUPLAZID[®] (pimavanserin) is prescribed.

Complete this form to enroll. Be sure to fill out all sections and sign everywhere indicated. **FORM CANNOT BE PROCESSED WITHOUT ALL REQUIRED SIGNATURES.**

To submit:

- Email to nuplazid@acadiaconnect.com
- Fax to 1-844-737-2224
- Or mail to PO Box 15713, Pittsburgh, PA 15244

For assistance:

- Call 1-844-737-2223, Monday to Friday, 8 AM-8 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

Where does the patient reside? ☐ Home ☐ Long-term care facility

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

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

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

First name Last name

Email Phone number (mobile preferred)

Primary contact: ☐ Patient ☐ Care partner

4 Insurance Information *Tell us about your insurance.*

Prescription drug plan (located on your health insurance card or ask health plan provider) Payer phone number

Cardholder name Plan ID number Medicare ID number

5 Prescriber & Pharmacy Information *Who prescribed your NUPLAZID medication?*

Prescriber full name (first and last) Phone number

Pharmacy that has already received the NUPLAZID prescription (if known) Pharmacy phone number

Allows healthcare providers and Acadia Connect® to share patient information as needed to provide Acadia Connect® services.

Patient's Name: _____ Date of Birth (MM/DD/YYYY): _____

DESCRIPTION OF THE PROGRAM:

The Acadia Connect® & Acadia Connect® Commercial Copay Card Program, or the "Program" or "Services," helps you and (if you are guardian or authorized representative) your ward ("patient") learn about, obtain, and access NUPLAZID® (pimavanserin), including through copay and related financial assistance for NUPLAZID. Program Terms and Conditions apply: <https://www.acadiacconnect.com/nuplazid/patient-caregivers>.

Required

SERVICES CONSENT (Required to participate in the Program) (see below for details)

☐ I consent to the Services as described below.

NUPLAZID AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION SIGNATURE. (Required to participate in the Program) (see below for details)

Sign Here

Patient/Authorized Representative: _____ Date: _____

Full name (please print): _____ Relationship to patient: _____

Additional care partners (optional) (see below for details)

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

CONSENT TO RECEIVE TEXTS (Optional)

☐ I consent ☐ I do not consent

I agree that Acadia may contact me via text message at the phone number on page 1 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 1-844-737-2223 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.

ACADIA NEWS AND UPDATES (Optional)

☐ I want to receive additional information from Acadia based on my health and caregiving interests.

I agree that Acadia Pharmaceuticals Inc. and its representatives and agents (collectively, "Acadia") may use and disclose personal data about me and (if I am a care partner) my patient to send promotional communications about Acadia products and services. To provide me with this service, Acadia may process health information about me or my patient (as applicable), such as diagnosis, symptoms, medication, and inferences derived from the same, and disclose this data to its service providers and affiliates, and as otherwise described in the Authorization for Disclosure of Health Information, below, and Acadia's privacy policy.

I may unsubscribe at any time.

SERVICES CONSENT (Required to participate in the Program)

I agree to enroll in the Services, or (if I am a care partner), I agree on behalf of the patient to enroll the patient in the Services. I agree that Acadia and its service providers may collect, use, and disclose health information and personal data about me and (if I am a care partner) the patient as necessary to facilitate participation in the Services and as otherwise described in the NUPLAZID Authorization for Disclosure of Health Information, below, and Acadia's privacy policy, available here: www.acadia.com/privacy. I also agree that Acadia may contact me and the patient, as applicable, at the contact information I have provided on this form, including by calling, texting, or emailing, for purposes related to participation in the Services.

NUPLAZID AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, on behalf of myself or (if I am a personal representative) my patient, hereby authorize and direct my or my patient's healthcare providers (including physicians, prescribers, providers of long-term care, and pharmacies) health insurance companies, specialty pharmacies, and each of their respective representatives, employees, staff, and agents (collectively "Providers"), and any care partners or other individuals whom I list on page 2 ("Additional Care Partners") to use Protected Health Information ("PHI") about me or my patient (as applicable), and disclose it to each other and to Acadia Pharmaceuticals Inc. and its representatives and agents (collectively "Acadia") to facilitate participation in the Services and to receive the Acadia News and Updates if I selected this option above (collectively "Program"). I understand that this PHI may include, without limitation, contact information (name, address, phone number, email) and information about healthcare (medical condition, treatment and medications, care management, and health insurance). 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 also authorize Acadia to disclose to Providers and Additional Care Partners for Program purposes any

information about me or (if I am a personal representative) my patient, that Acadia may create or receive. I understand that information used or disclosed pursuant to this authorization may no longer be protected by certain state or federal privacy laws and may be subject to redisclosure. I understand that I may refuse to sign this authorization, and my refusal will not affect the treatment I receive or my patient (as applicable) receives from Providers, nor will it affect my or my patient's (as applicable) enrollment or eligibility for health insurance benefits to which I am or my patient (as applicable) is otherwise entitled. However, if I refuse to sign this authorization, I or my patient (as applicable) will not be able to participate in the Program, as the information used and disclosed as described in this form is necessary to facilitate participation in the Program. I also understand that I may cancel (revoke) this authorization at any time and request a signed copy of this authorization by calling 1-844-737-2223 or by writing to Acadia Connect®, PO Box 15713, Pittsburgh, PA 15244; however, this cancellation will not apply to any 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 5 years or for a shorter period dictated by applicable state law.

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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