ONCE-DAILY
NUPLAZID®
(pimavanserin) 34mg capsules

Service Request Form
Long-Term Care

acadia connect™
Patient & Caregiver Support

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

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 accompanying full Prescribing Information, also available at NUPLAZIDhcp.com.

Please complete and fax the Service Request Form to **1-844-737-2224** or email to **acadiaconnect@lashgroup.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

*Facility name | *DOB (MM/DD/YYYY) | Gender

*Resident/Caregiver email | Resident phone number

Caregiver name | Caregiver phone number

*Preferred contact: ☐ Resident ☐ Caregiver | Preferred language (if not English)

Section required if resident has insurance ☐ Resident does not have insurance

*Prescription drug plan | *Phone number

*ID number | Plan number

Cardholder name | Group number

Relationship to cardholder | PCN/BIN number

*Resides at:

☐ Skilled nursing facility/nursing home
☐ Assisted living

*Primary facility contact | *Job title | *Address

*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 DIAGNOSIS INFORMATION/PRESCRIBER AUTHORIZATION
To be completed by prescribing physician, nurse, or facility pharmacist.

*Please confirm diagnosis: ☐ Hallucinations and delusions associated with Parkinson's disease (PD) psychosis or ☐ Other diagnosis: _____

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 (i.e., 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.

By signing this authorization, I authorize my health plans, physicians, long-term care and other healthcare providers, pharmacies, and health insurance companies, and each of their respective representatives, employees, staff, and agents (collectively "Providers") to use and disclose my Protected Health Information ("PHI"), which is defined to include, but is not limited to, my name, address and phone number, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription to Acadia Pharmaceuticals Inc. and its representatives or agents (collectively "Acadia"). I authorize and direct my Providers to use my PHI to make disclosures of PHI to Acadia for the following purposes:

- Reimbursement support associated with the filling of my prescription for NUPLAZID, including the performance of an insurance verification and assisting in securing of any insurance coverage for NUPLAZID to which I am entitled
- Facilitating the provision of patient assistance, reduced cost medication, and/or other NUPLAZID-related services offered by Acadia
- Receiving marketing and promotional communications related to my disease condition, NUPLAZID, and other information from Acadia. I hereby give consent to Acadia, its affiliates and their agents and representatives, and my Providers to send communications and information to me via the contact information provided.

With respect to any disclosures by my pharmacies, I understand that my pharmacies will receive remuneration (payment) from Acadia for making disclosures of PHI and/or support services to Acadia.

I understand that once my PHI is disclosed under this authorization, it is no longer protected by Federal privacy laws, including HIPAA, and may be further disclosed by Acadia.

I understand that I may refuse to sign this authorization and that treatment, payment, or eligibility for benefits is not conditioned on my signing this authorization.

I understand that I will be provided with a signed copy of this authorization, by the Provider who collects it from me.

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 may cancel (revoke) this authorization at any time by mailing a letter requesting such cancellation to Acadia Connect, PO Box 220305, Charlotte, NC 28222-0305, but that this cancellation will not apply to any PHI already used or disclosed through this authorization before notice of the cancellation is received by my Providers.

» 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.
- **Adverse Reactions:** The common adverse reactions (≥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.

ACADIA™ acadia connect™ ONCE-DAILY NUPLAZID® (pimavanserin) 34mg capsules