INGREZZA® (valbenazine) capsules | Treatment Form

INBRACE™ Support that surrounds you with care.

For additional assistance, call 84-INGREZZA (844-647-3992), 8 AM–8 PM ET, M–F.

INSTRUCTIONS: Please complete and fax this page to 844-394-7155. Alternatively, if your email system is set up to be in compliance with the HIPAA Security Rule (45 CFR 164.302 – 318), you may also email the Treatment Form to neurocrine@sonexushealth.com.

1 PATIENT INFORMATION

First Name:	Last Name:		DOB: / /
Address:	City:	State:	ZIP:
Last 4 digits of the SSN:	US Resident: ☐ Yes ☐ No	Gender: ☐ Male ☐ Female	
Preferred Phone:	Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening	Email:	

Ship Prescription to (optional): ☐ Caregiver ☐ HCP office

☐ **I consent to have my prescription shipped to preference above.**

☐ **I have read and agree to the Patient Authorization on page 3.** **Patient Signature:** Date:

Alternate Contact/Caregiver: Alt Contact/Caregiver Phone:

2 PATIENT INSURANCE INFORMATION–Please attach a copy of the patient's insurance card. (Check below if no insurance)

☐ Patient does not have insurance.	**Medical Insurance Name:**	**Pharmacy Insurance Name:**	
Phone:	Member ID #:	Phone:	Pharmacy ID #:
Policyholder Name & DOB: / /		BIN:	PCN:

3 CLINICAL INFORMATION

Primary Diagnosis Code Category: ☐ **Tardive Dyskinesia (G24.01)** ☐ Other diagnosis: Allergies:

4 PRESCRIPTION FOR INGREZZA CAPSULES

PRESCRIPTION INSTRUCTIONS:
Check **Initial Rx, Maintenance Rx** or BOTH. If in-office samples were used, there is no need to check the **Initial Rx** box.

☐ **Initial Rx**
40 mg once daily x 7 days
80 mg once daily x 23 days
30-day supply
No refills

☐ **Maintenance Rx**
80 mg once daily
30-day supply
Maintenance Rx Refills #_____

OR

☐ Other Rx:
Sig: _____
Quantity: _____
Other Rx Refills: _____

Preferred Pharmacy if applicable: ☐ Amber Pharmacy ☐ Orsini Healthcare ☐ PANTHERx® Specialty Pharmacy ☐ No Preference

5 PRESCRIBER INFORMATION

Prescriber Name:			Prescriber NPI #:
Facility Name:			Prescriber Tax ID #:
Address:	City:	State:	ZIP:
Phone:	Fax:		
Office Contact Name:	Contact Email Address:		Office Contact Phone:

6 INGREZZA START PROGRAM (OPTIONAL)

Free Trial Program Rx (New Patients)

I authorize the INBRACE Program Pharmacy to dispense a free one-time 37-day supply of INGREZZA. This program is only available to adults diagnosed with tardive dyskinesia 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. We reserve the right to modify or cancel the program at any time.

☐ **Free Trial Program Rx**
40 mg once daily x 7 days
80 mg once daily x 30 days
No refills

OR

☐ Free Trial Other Rx:
Sig: _____
Quantity: _____
No Refills

7 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Treatment 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 I have obtained my patient's written authorization in accordance with applicable state and federal law including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of Neurocrine Biosciences, Inc. (including, but not limited to, Sonexus Health LLC and INGREZZA dispensing pharmacies) for benefits eligibility, coverage authorization and coordination and dispensing of INGREZZA. I authorize the forwarding of this prescription and information to a dispensing specialty pharmacy. 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, 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)*

Please see Indication and Important Safety Information on page 2.

Neurocrine BIOSCIENCES

IMPORTANT INFORMATION

INDICATION & USAGE

INGREZZA (valbenazine) capsules is indicated for the treatment of adults with tardive dyskinesia.

IMPORTANT SAFETY INFORMATION

WARNINGS & PRECAUTIONS

Somnolence

INGREZZA can cause somnolence. Patients should not perform activities requiring mental alertness such as operating a motor vehicle or operating hazardous machinery until they know how they will be affected by INGREZZA.

QT Prolongation

INGREZZA may prolong the QT interval, although the degree of QT prolongation is not clinically significant at concentrations expected with recommended dosing. INGREZZA should be avoided in patients with congenital long QT syndrome or with arrhythmias associated with a prolonged QT interval. For patients at increased risk of a prolonged QT interval, assess the QT interval before increasing the dosage.

ADVERSE REACTIONS

The most common adverse reaction (≥5% and twice the rate of placebo) is somnolence. Other adverse reactions (≥2% and >placebo) include: anticholinergic effects, balance disorders/falls, headache, akathisia, vomiting, nausea, and arthralgia.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit MedWatch at www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see accompanying INGREZZA full Prescribing Information or visit www.INGREZZA.com/HCP

PATIENT SERVICES/OTHER COMMUNICATIONS

Patient Authorization

Program Opt-In

I authorize Neurocrine, and companies working with Neurocrine, to provide me with support services related to Neurocrine products, marketing materials, information about Neurocrine products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics. Services may also include, but are not limited to: online support, financial assistance services, reimbursement support, medication compliance and persistence, and other treatment related services, as well as any information or materials related to such services (collectively called "Support Services"). I agree and acknowledge that any nurse or other person providing Support Services is not employed by my healthcare professional. I authorize Neurocrine, and companies working with Neurocrine, to contact me to provide Support Services and information by mail, e-mail, fax, telephone call, text message, and other means. I understand that I do not have to agree to receive the Support Services and that I can still receive INGREZZA, as prescribed by my physician. I understand that I am under no obligation to purchase INGREZZA, whether or not I have started INGREZZA under a free trial program offered by Neurocrine. I understand that I cannot seek reimbursement from any health insurance or third party, including state or federally funded programs, for free trial product nor can it be counted towards my true out-of-pocket costs. I certify that I am at least eighteen (18) years of age. I understand that I may opt-out of receiving the Support Services by notifying 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.

Authorization for Use and Disclosure of Protected Health Information

I also authorize Neurocrine, companies working with Neurocrine, my healthcare provider and pharmacy to use and disclose to Neurocrine, and companies working with Neurocrine, my Protected Health Information ("PHI"), such as information provided on the INGREZZA Treatment Form, my prescription, insurance, medical therapy information and other PHI in connection with the Support Services as described above. I authorize the disclosure of my PHI to specific individuals who are identified on the INGREZZA Treatment Form. 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 I do not have to agree to the use and disclosure of my PHI in order to receive INGREZZA, but without this authorization I may not be able to receive the Support Services. While my PHI will be protected and used and disclosed only for the intended purposes, 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 the terms of this authorization against further re-disclosure. 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.