INGREZZA® (valbenazine) capsules

START PROGRAM FORM

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.

1 PATIENT INFORMATION

First Name*:

Last 4 digits of the SSN:

Last Name*:

DOB*: / /

Address:

City:

State:

ZIP:

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

US Resident: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female

Email:

Preferred Phone:

Is Preferred Phone a Mobile Number? ☐ Yes ☐ No

Ship Prescription to (optional): ☐ Care Partner ☐ HCP office ☐ LTC facility

I consent to have my Rx shipped to the preference noted and for the INBRACE Program Pharmacy to contact the Care Partner or healthcare provider.

Patient/Authorized Representative Signature:

Date:

Description of Authorized Representative's Authority:

Alternate Contact/Care Partner Name:

Alternate Contact/Care Partner Phone:

2 PRESCRIBER INFORMATION

Prescriber Name*:

Prescriber NPI*:

Facility Name:

Address:

City:

State:

ZIP:

Phone:

Fax:

Office/Facility Contact Name:

Office/Facility Contact Phone:

Office/Facility Contact Fax:

Office/Facility Contact Email:

3 LTC/SNF/ASSISTED LIVING RESIDENTS† ONLY:

Resident Room Number:

Ship Prescription to: ☐ Facility Contact ☐ Facility Pharmacy

Facility Pharmacy Name:

Facility Pharmacy Phone:

Facility Pharmacy Address:

City:

State:

ZIP:

†Residents currently covered under Medicare Part A stay are not eligible.

4 CLINICAL INFORMATION

☐ Tardive Dyskinesia (G24.01) ☐ Huntington's Chorea (G10) ☐ Other diagnosis:

Allergies:

5 INGREZZA START PROGRAM*

Free Trial Program Rx (New Patients)

This program is only available to adults diagnosed with tardive dyskinesia or Huntington's chorea 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. Neurocrine reserves the right to modify or cancel the program at any time. I authorize the INBRACE Program Pharmacy to dispense a free one-time, 1-month supply of INGREZZA.

Select one of the following **(NO REFILLS)**:

☐ 40 mg once a day x 7 days and 80 mg once a day x 21 days ***OR***

☐ 40 mg once a day x 30 days

☐ Other Rx:

Sig:_____ Quantity:_____

6 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Start Program 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, where required by federal and/or state law, I have obtained my patient's written legal permission to share identifiable information with Neurocrine Biosciences, Inc., its agents and pharmacies, including but not limited to the INBRACE Support Program Pharmacy. I authorize the forwarding of this prescription and information to a dispensing pharmacy for the INGREZZA Start Program. 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, LTC facility, or pharmacy, 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 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