Daybue™ (trofinetide)

PATIENT/PARENT/LEGAL GUARDIAN CONSENT FORM

acadia connect®

Acadia Connect® is a patient support program that connects you and your family with educational support and resources throughout the DAYBUE™ (trofinetide) treatment journey. The team will help you with

- Understanding and verifying insurance coverage
- Information on appropriate financial assistance options
- Support and education throughout the DAYBUE treatment journey

Consent is required to enroll a patient in Acadia Connect.

The authorized parent/legal guardian should complete, sign, and submit the completed form via fax to 1-888-385-2748 or email to DAYBUE@AcadiaConnect.com.

1 PATIENT/PARENT/LEGAL GUARDIAN INFORMATION

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____ Gender: _____

Address: _____ City: _____ State: _____ ZIP Code: _____ Date of Birth (MM/DD/YYYY): _____

PARENT/LEGAL GUARDIAN INFORMATION

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Relationship to Patient: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Home Phone #: _____ Mobile Phone #: _____

Work Phone #: _____ Preferred Phone #: ☐ Home ☐ Work ☐ Mobile

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening Can We Leave a Message? ☐ Yes ☐ No

Email Address: _____

2 PRESCRIBER INFORMATION

Prescriber Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____

3 PATIENT/PARENT/LEGAL GUARDIAN HIPAA AUTHORIZATION (Please read and sign below if you agree.)

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 DAYBUE and Acadia Connect support services. 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 Form and any prescription. I agree to be enrolled in the Acadia Copay Card Program if eligible, and if I am confirmed eligible, I understand that Copay Card information will be sent to my specialty pharmacy, along with my prescription. I understand any assistance with my cost-sharing or copayment for DAYBUE will be made in accordance with the Program Terms and Conditions. I understand that pharmacies may receive remuneration (payment) from Acadia for providing patient support services and disclosing associated PHI to Acadia pursuant to this Form.

I further authorize Acadia to use my PHI and disclose it to third parties, including, but not limited to, specialty pharmacies, health plans, insurance companies, and patient assistance programs solely in relation to my obtaining DAYBUE and/or Acadia Connect product support services, including investigating insurance benefits, eligibility, and coverage; providing financial assistance for copay or out-of-pocket payments; eligibility for free medication supply; coordinating care; coordinating the delivery of medication.

I authorize Acadia and Providers to communicate with me via phone, text, or email, using the contact information I have provided on this form, for all of the purposes mentioned above. I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify Acadia Connect promptly if any of my numbers change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages by responding STOP to any text. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message.

I also authorize Acadia to disclose to my DAYBUE Providers any PHI about me that Acadia may create or receive. I understand that once my PHI is disclosed to or by Acadia pursuant to this Form, 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 Form, 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. I also understand that I may cancel (revoke) this authorization at any time by mailing a letter requesting such cancellation to the address below; however, this cancellation will not apply to any PHI already used or disclosed in reliance on this Form before notice of the cancellation is received by my Providers. 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 will be provided with a signed copy of this authorization by the Provider who collects it from me.

Further information concerning Acadia's privacy practices can be found at https://www.acadia-pharm.com/privacy. If you are a resident of California, a description of the personal information collected by Acadia and your rights under the California Consumer Privacy Act can be found at this address. Address to Opt Out of Communications or to Cancel This Form: Acadia Connect, 1710 Shelby Oaks Dr. Ste 3, Memphis, TN 38134.

Patient/Parent/Legal Guardian (print name): _____

Sign Here Patient/Parent/Legal Guardian: _____ Date: _____

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