Daybue™ (trofinetide)

PRESCRIPTION AND ENROLLMENT FORM

acadia connect®

Healthcare providers:

- Please submit completed enrollment form, copy of all insurance cards (front and back), and copy of patient's clinical chart notes to Acadia Connect®
- Have the parent/legal guardian read page 3 and sign where indicated
- Fax the completed form to Acadia Connect at 1-888-385-2748
- If your office has not received a confirmation fax that your enrollment form has been received within one (1) business day after submission, please resubmit or call Acadia Connect at 1-844-737-2223, Monday to Friday, 8AM to 8PM ET

1 PATIENT AND PARENT/LEGAL GUARDIAN INFORMATION

PATIENT INFORMATION

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

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

Date of Birth (MM/DD/YYYY): _____ Gender: _____

PARENT/LEGAL GUARDIAN INFORMATION

First Name: _____ Last Name: _____

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 INSURANCE INFORMATION ☐ No insurance

Primary Medical Insurance Name: _____

Policy #: _____ Group #: _____ Phone #: _____

Policy Holder's Full Name: _____

Date of Birth (MM/DD/YYYY): _____ Relationship to Patient: _____

Prescription Drug Insurance Name: _____ Rx Phone #: _____

Rx Group #: _____ Rx PCN #: _____ Rx BIN #: _____

Secondary Medical Insurance Name: _____

Policy #: _____ Group #: _____ Phone #: _____

Policy Holder's Full Name: _____

Date of Birth (MM/DD/YYYY): _____ Relationship to Patient: _____

Prescription Drug Insurance Name: _____ Rx Phone #: _____

Rx Group #: _____ Rx PCN #: _____ Rx BIN #: _____

3 ADDITIONAL HEALTHCARE PROVIDERS (Please complete the table with information to the best of your knowledge.)

CARE TEAM ROLE	HEALTHCARE PROVIDER OFFICE	NAME	OFFICE PHONE/FAX
Pediatrician			
Primary Care or General Practitioner			
Neurologist			
Gastroenterologist			
Geneticists/Genetic Physician			
Other Healthcare Providers			

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

4 PRESCRIBER INFORMATION

Prescriber First Name: _____ Last Name: _____

Prescriber Specialty: _____ Practice Name: _____

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

NPI #: _____ Medical Provider ID #: _____ DEA #: _____

Phone #: _____ Fax #: _____

Office Contact: _____ Contact Phone #: _____ Office Email: _____

5 CLINICAL INFORMATION

Applicable ICD-10 Code: _____ Has the Patient Had Genetic Testing? ☐ Yes ☐ No Date of Test: _____
(methyl-CpG binding protein 2 [*MECP2*])

Genetic Test Company: _____

Genetic Test Results: _____

6 PHARMACY PRESCRIPTION

Drug: DAYBUE™ (trofinetide) 200 mg/mL, Oral Solution Prescribing Directions: Take _____ mL Twice Daily Day Supply: _____ Refills: _____

Patient's Weight (kg): _____ Administration: ☐ Oral ☐ Gastrostomy Tube Type: ☐ NeoMed® Oral Dispenser ☐ ENFit® ☐ Luer Lock Syringe

Additional Prescribing Directions: _____

Patient's Allergies: ☐ NKDA Please List: _____

Current Medications: _____

In their monthly shipments, all patients will receive ancillary materials required for the treatment method selected by the prescriber.

7 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 DAYBUE that I have elected to prescribe. I direct Acadia to convey, on my behalf, any prescription-related PHI and other prescribing information delivered to Acadia for DAYBUE to the dispensing pharmacy chosen by or for the patient, to the patient's health insurance company, and to other third parties as may be necessary for dispensing the patient's prescription for DAYBUE, with verifying the patient's insurance coverage for DAYBUE, providing information regarding payer coverage and benefits and how to prepare prior authorization requests, coverage determination appeals, or other coverage issues, and/or assisting with patient assistance and support or reduced-cost DAYBUE. 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 DAYBUE, including but not limited to via email, fax, and telephone. I appoint Acadia as my agent for the purpose of conveying this prescription to the appropriate dispensing pharmacy. I certify that DAYBUE is medically necessary and in the best interest of the named patient.

My signature below certifies that I have read, understand, and agree to the Prescriber Authorization statement above.

Sign Here Signature (Dispense as Written): _____ Date: _____
No Stamp Signature

OR

Sign Here Signature (Substitution Allowed): _____ Date: _____
No Stamp Signature

Print Name: _____

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

8 ADDITIONAL HEALTHCARE PROVIDERS (Please complete the table with information to the best of your knowledge.)

CARE TEAM MEMBER ROLES	PROVIDER OFFICE	NAME	OFFICE PHONE/FAX
Pediatrician			
Family/Internal Medicine			
Neurologist			
Gastroenterologist			
Other Healthcare Providers			

9 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 co-payment 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 www.acadia.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.

I further authorize Acadia Pharmaceuticals Inc. to discuss the coordination of the patient's care with the following family member(s) and/or caregiver(s). These individual(s) have my full permission, on behalf of the patient, to obtain and disclose personal and medical information about the patient, Acadia, and its agents and contractors.

Authorized Representative(s) (please print):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

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

Please submit completed enrollment form via fax to 1-888-385-2748 or email to DAYBUE@AcadiaConnect.com

ACADIA®