

This is your NUPLAZID Authorization for Disclosure of Health Information. **Signing this form will allow us to communicate and coordinate your services with other healthcare providers such as your doctor, insurance company, and pharmacy to help support your ongoing treatment.** To avoid any delays with your Acadia Connect® services, please sign the form as indicated below. If you have any questions, please call 1-844-737-2223.

» *Print patient name

*Prescriber's name

*Date of birth (MM/DD/YYYY)

Address

DESCRIPTION OF THE PROGRAM:

The Acadia Connect® & Acadia Connect® Commercial Copay Card Program, or the "Program" or "Services," helps you and (if you are a guardian or an authorized representative) your ward ("patient") learn about, obtain, and access NUPLAZID, including through copay and related financial assistance for NUPLAZID. Program Terms and Conditions apply: <https://www.acadiacconnect.com/nuplazid/patient-caregivers>.

SERVICES CONSENT (Required to participate in the Program) (see below for details)

Required ☐ *I consent to the Services as described below.

NUPLAZID AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (Required to participate in the Program) (see below for details)

Sign Here *Patient/Authorized Representative: _____ *Date _____

Full name (please print): _____ Relationship to patient: _____

Additional care partners (optional) (see below for details)

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

CONSENT TO RECEIVE TEXTS (Optional)

☐ I consent ☐ I do not consent

Preferred Phone Number: _____

I agree that Acadia may contact me via text message at the above phone number regarding the Program and other Acadia products and services. I confirm that I am the subscriber for the mobile telephone number(s) I provided on this form, and I agree to notify Acadia promptly by calling 1-844-737-2223 or by mailing Acadia Connect®, PO Box 15713, Pittsburgh, PA 15244 if any of my numbers change in the future. I understand that my wireless service provider's message and data rates may apply. I can opt out of future communications by responding STOP to any text. I UNDERSTAND THAT THESE COMMUNICATIONS MAY USE PRERECORDED/ARTIFICIAL VOICE MESSAGES AND/OR AN AUTOMATED SYSTEM AND THAT I DO NOT NEED TO AGREE TO RECEIVE CALLS OR TEXTS AS A CONDITION OF PURCHASING OR RECEIVING ANY GOODS OR SERVICES FROM ACADIA.

ACADIA NEWS AND UPDATES (Optional)

☐ I want to receive additional information from Acadia based on my health and caregiving interests.

Preferred Email: _____

I agree that Acadia Pharmaceuticals Inc. and its representatives and agents (collectively, "Acadia") may use and disclose personal data about me and (if I am a care partner) my patient to send promotional communications about Acadia products and services. To provide me with this service, Acadia may process health information about me or my patient (as applicable), such as diagnosis, symptoms, medication, and inferences derived from the same, and disclose this data to its service providers and affiliates, and as otherwise described in the Authorization for Disclosure of Health Information, below, and Acadia's privacy policy.

I may unsubscribe at any time.

SERVICES CONSENT (Required to participate in the Services)

I agree to enroll in the Services, or (if I am a care partner), I agree on behalf of the patient to enroll the patient in the Services. I agree that Acadia and its service providers may collect, use, and disclose health information and personal data about me and (if I am a care partner) the patient as necessary to facilitate participation in the Services and as otherwise described in the NUPLAZID Authorization for Disclosure of Health Information, below, and Acadia's privacy policy, available here: www.acadia.com/privacy. I also agree that Acadia may contact me and the patient, as applicable, at the contact information I have provided on this form, including by calling, texting, or emailing, for purposes related to participation in the Services.

**NUPLAZID AUTHORIZATION FOR DISCLOSURE OF
HEALTH INFORMATION**

I, on behalf of myself or (if I am a personal representative) my patient, hereby authorize and direct my or my patient's healthcare providers (including physicians, prescribers, providers of long-term care, and pharmacies) health insurance companies, specialty pharmacies, and each of their respective representatives, employees, staff, and agents (collectively "Providers"), and any care partners or other individuals whom I list below ("Additional Care Partners") to use Protected Health Information ("PHI") about me or my patient (as applicable), and disclose it to each other and to Acadia Pharmaceuticals Inc. and its representatives and agents (collectively "Acadia") to facilitate participation in the Services and to receive the Acadia News and Updates if I selected this option above (collectively "Program"). I understand that this PHI may include, without limitation, contact information (name, address, phone number, email) and information about healthcare (medical condition, treatment and medications, care management, and health insurance). I understand that pharmacies may receive remuneration (payment) from Acadia for providing patient support services and disclosing associated PHI to Acadia pursuant to this authorization.

I also authorize Acadia to disclose to Providers and Additional Care Partners for Program purposes any information about me or (if I am a personal representative) my patient, that Acadia may create or receive. I understand that information used or disclosed pursuant to this authorization may no longer be protected by certain state or federal privacy laws and may be subject to redisclosure. I understand that I may refuse to sign this authorization, and my refusal will not affect the treatment I receive or my patient (as applicable) receives from Providers, nor will it affect my or my patient's (as applicable) enrollment or eligibility for health insurance benefits to which I am or my patient (as applicable) is otherwise entitled. However, if I refuse to sign this authorization, I or my patient (as applicable) will not be able to participate in the Program, as the information used and disclosed as described in this form is necessary to facilitate participation in the Program. I also understand that I may cancel (revoke) this authorization at any time and request a signed copy of this authorization by calling 1-844-737-2223 or by writing to Acadia Connect®, PO Box 15713, Pittsburgh, PA 15244; however, this cancellation will not apply to any information already used or disclosed in reliance on this authorization before notice of the cancellation is received. I understand that this authorization is valid for a period of 5 years or for a shorter period dictated by applicable state law.