INFORMED CONSENT FOR MEDICATION
Dosage and/or Side Effect information last revised on 09/23/2016

Completion of this form is voluntary. If not completed, the medication cannot be administered without a court order unless in an emergency.
This consent is maintained in the client’s record and is accessible to authorized users.

<table>
<thead>
<tr>
<th>MEDICATION CATEGORY</th>
<th>MEDICATION</th>
<th>RECOMMENDED DAILY TOTAL DOSAGE RANGE</th>
<th>ANTICIPATED DOSAGE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atypical antipsychotic</td>
<td>Nuplazid (pimavanserin)</td>
<td>34mg/ day</td>
<td></td>
</tr>
</tbody>
</table>

The anticipated dosage range is to be individualized, may be above or below the recommended range but no medication will be administered without your informed and written consent.
Recommended daily total dosage range of manufacturer, as stated in Physician’s Desk Reference (PDR) or another standard reference.
This medication will be administered □ Orally □ Injection □ Other – Specify:

1. Reason for Use of Psychotropic Medication and Benefits Expected (note if this is ‘Off-Label’ Use)
   Include DSM-5 diagnosis or the diagnostic “working hypothesis.”

2. Alternative mode(s) of treatment other than OR in addition to medications include
   Note: Some of these would be applicable only in an inpatient environment.
   □ Environment and/or staff changes □ Rehabilitation treatments/therapy (OT, PT, AT)
   □ Positive redirection and staff interaction □ Treatment programs and approaches (habilitation)
   □ Individual and/or group therapy □ Use of behavior intervention techniques
   Other Alternatives:

3. Probable consequences of NOT receiving the proposed medication are
   Impairment of □ Work Activities □ Family Relationships □ Social Functioning

   Possible increase in symptoms leading to potential
   □ Use of seclusion or restraint □ Limits on recreation and leisure activities
   □ Limits on access to possessions □ Intervention of law enforcement authorities
   □ Limits on personal freedoms □ Risk of harm to self or others
   □ Limit participation in treatment and activities

   Other Consequences:

   Note: These consequences may vary depending upon whether or not the individual is in an inpatient setting. It is also possible that in unusual situations, little or no adverse consequences may occur if the medications are not administered.

See Page 2

Client Initial ___________ Date ______________
4. Possible side effects, warnings, and cautions associated with this medication are listed below. This is not an all-inclusive list but is representative of items of potential clinical significance to you. For more information on this medication, you may consult further with your physician or refer to a standard text, such as the PDR. As part of monitoring some of these potential side effects, your physician may order laboratory or other tests. The treatment team will closely monitor individuals who are unable to readily communicate side effects in order to enhance care and treatment.

The most common side effects include nausea, peripheral edema, and a confused state.

Less common side effects consist of constipation, gait disturbance, and hallucinations

Rare side effects include QT interval prolongation. Nuplazid should be avoided in patients with known QT prolongation or in combination with other drugs known to prolong QT interval including Class 1A antiarrhythmics (e.g., quinidine, procainamide) or Class 3 antiarrhythmics (e.g., amiodarone, sotalol), certain antipsychotic medications (e.g., ziprasidone, chlorpromazine, thioridazine), and certain antibiotics (e.g., gatifloxacin, moxifloxacin). Nuplazid should also be avoided in patients with a history of cardiac arrhythmias, as well as other circumstances that may increase the risk of the occurrence of torsade de pointes and/or sudden death, including symptomatic bradycardia, hypokalemia or hypomagnesaemia, and the presence of congenital prolongation of the QT interval.

**Black Box Warning** Antipsychotic drugs increase the all-cause risk of death in elderly patients with dementia-related psychosis. Analyses of 17 dementia-related psychosis placebo-controlled trials (modal duration of 10 weeks and largely in patients taking typical antipsychotic drugs) revealed a risk of death in the drug-treated patients of between 1.6- to 1.7-times that in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in placebo-treated patients.

See PDR for an all-inclusive list of side effects.

**By my signature below, I GIVE consent for the named medication on Page 1 and anticipated dosage range. My signature also indicates that I understand the following:**

1. I can refuse to give consent or can withdraw my consent at any time with written notification to the institution director or designee. This will not affect my right to change my decision at a later date. If I withdraw consent after a medication is started, I realize that the medication may not be discontinued immediately. Rather, it will be tapered as rapidly as medically safe and then discontinued so as to prevent an adverse medical consequence, such as seizures, due to rapid medication withdrawal.
2. Questions regarding this medication can be discussed with the Interdisciplinary Team, including the physician. The staff contact person can assist in making any necessary arrangements.
3. Questions regarding any behavior support plan or behavior intervention plan, which correspond with the use of the medication, can be directed to the client’s social worker, case manager, or psychologist.
4. I have the right to request a review at any time of my record, pursuant to § 51.30(4)(d) or § 51.30(5)(b).
5. I have a legal right to file a complaint if I feel that client rights have been inappropriately restricted. The client’s social worker, case manager, or agency/facility client rights specialist may be contacted for assistance.
6. My consent permits the dose to be changed within the anticipated dosage range without signing another consent.
7. I understand the reasons for the use of the medication, its potential risks and benefits, other alternative treatment(s), and the probable consequences that may occur if the proposed medication is not given. I have been given adequate time to study the information and find the information to be specific, accurate, and complete.
8. This medication consent is for a period effective immediately and not to exceed fifteen (15) months from the date of my signature. The need for and continued use of this medication will be reviewed at least quarterly by the Interdisciplinary Team. The goal, on behalf of the client, will be to arrive at and maintain the client at the minimum effective dose.

<table>
<thead>
<tr>
<th>SIGNATURES</th>
<th>DATE SIGNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client – If Presumed Competent to Consent/Parent of Minor/Guardian (POA-HC)</td>
<td>Relationship to Client</td>
</tr>
<tr>
<td>□ Parent</td>
<td>□ Guardian (POA-HC)</td>
</tr>
<tr>
<td>Staff Present at Oral Discussion</td>
<td>Title</td>
</tr>
<tr>
<td>Client / Parent of Minor / Guardian (POA-HC) Comments</td>
<td></td>
</tr>
</tbody>
</table>

As parent/guardian (POA-HC) was not available for signature, he/she was verbally informed of the information in this consent.

<table>
<thead>
<tr>
<th>Verbal Consent</th>
</tr>
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<tbody>
<tr>
<td>Obtained by – PRINT – Staff Name</td>
</tr>
<tr>
<td>□ Yes</td>
</tr>
<tr>
<td>Obtained from – PRINT – Parent / Guardian (POA-HC) Name</td>
</tr>
</tbody>
</table>