## lovement Disorders Enrollment Form



Fax Referral To: 1-855-297-1270 Phone: 1-888-280-1190 NCPDP: 4026325

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras. PR 00927

Six Simple Steps to Submitting a Referral **PATIENT INFORMATION** (Complete or include demographic sheet) \_\_\_\_\_\_DOB: \_\_\_\_\_\_Gender: Male Female Patient Name: City, State, ZIP Code: Address: Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below) Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls. emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. Primary Phone: \_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_\_ Email: Parent/Caregiver/Legal Guardian Name (Last, First): \_\_\_\_\_Relationship to patient: \_\_\_\_\_ 2 PRESCRIBER INFORMATION State License #: Prescriber's Name: \_\_\_\_\_\_ State Licen: NPI #: \_\_\_\_\_ DEA #: \_\_\_\_ Group or Hospital: \_\_\_\_\_ Prescriber's Name: \_\_\_\_\_ \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_ Address: \_\_\_\_\_\_ Phone: \_\_\_\_\_ Fax\_\_\_\_\_ Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_ 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back) 4 DIAGNOSIS AND CLINICAL INFORMATION Needs by Date: \_\_\_\_\_\_ Ship to: Patient Office Other: \_\_\_\_\_ Diagnosis (ICD-10): G24.01 Tardive Dyskinesia (TD) G10 Huntington's Chorea (HD) G72.3 Periodic Paralysis Other Code: \_\_\_\_\_ Description \_\_\_\_\_ **Patient Clinical Information:** 

Height: \_\_\_\_in/cm

Allergies:

Weight: lb/kg

## **Movement Disorders Enrollment Form**

Please Complete Patient and Prescriber information				
Patient Name:	Patient DOB:Patient Phone:			
Prescriber Name:	Prescriber Phone:			
5 PRESCRIPTION INFORMATION				
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Austedo Initial Titration Rx-TD	☐ 6 mg ☐ 9 mg ☐ 12 mg	Administer 9 mg l	by mouth twice a day during Week 1 by mouth twice a day during Week 2 by mouth twice a day during Week 3 by mouth twice a day during Week 4	Quantity: 30-day supply Refills: None
Austedo Maintenance Rx-TD	6 mg 9 mg 12 mg	Administer two 12 mg tablets twice a day by mouth (48 mg/day)  Other		Quantity: Refills:
Austedo Initial Titration RX-HD	☐ 6 mg ☐ 9 mg ☐ 12 mg	Administer 6 mg by mouth once a day during Week 1 Administer 6 mg by mouth twice a day during Week 2 Administer 9 mg by mouth twice a day during week 3 Administer 12 mg by mouth twice a day during Week 4		Quantity: 30-day supply Refills: None
Austedo Maintenance Rx-HD	6 mg 9 mg 12 mg	Administer two 12 mg tablets twice a day by mouth (48 mg/day)  Other		Quantity: Refills:
☐ Dichlorphenamide	☐ 50 mg	Take tablet(s) by mouth daily.		Quantity: Refills:
☐ Ingrezza Initial Rx	☐ 40 mg ☐ 80 mg	Administer 40 mg by mouth once daily x 7 days then 80 mg by mouth once daily x 23 days.  Other		Quantity: Refills: None
☐ Ingrezza Maintenance Rx	☐ 80 mg	Administer 80 mg by mouth once daily		Quantity: 30 Refills:
☐ Ingrezza Maintenance Rx	☐ 40 mg	Administer 40 mg by mouth once a day		Quantity: 30 Refills:
☐ Ingrezza Maintenance Rx	☐ 60 mg	Administer 60 mg by mouth once a day		Quantity: 30 Refills:
☐ Ingrezza Maintenance Rx	Other	Other		
Patient is interested in patient support programs	STAMPS	STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration		needed for administration
6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)				
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute  Prescriber's Signature:			May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic prescription				

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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