Ingrezza® Enrollment Form

Patient Data

Patient Name: ______________________________ Birthdate: ______________

Sex: ❑ Male ❑ Female Height: ______ Weight: _______ lbs kg

SSN #: X X X - X X - ______________________________

Known Allergies: ______________________________

Address: ______________________________

City: ________________ State: ______________ Zip: ______________

Home Phone: ____________________ Cell Phone: ____________________

Primary Language: ______________________________

Alternate Caregiver Name: ______________________________

Phone of Caregiver: ______________________________

Ins. Data

Primary Insurance: ______________________________

Secondary Insurance: ______________________________

Policy: ______________________________ Group#: ____________

Policy: ______________________________ Group#: ____________

Diagnosis

❑ G24.01 Tardive Dyskinesia (TD) ❑ Other: ______________________________ ICD 10 code: ________________

Clinical Information

Please attach clinical notes, therapy history, AIMS testing and medication list to expedite the prior authorization.

Has patient had prior treatment for this diagnosis? ❑ Yes ❑ No

Date(s) of previous therapy and medication: ______________________________

____

Reason(s) for discontinuation : ______________________________

____

AIMS Score: ________________________ Date AIMS test was completed: _________/_________/_________

Is prescriber willing to complete peer-to-peer review if authorization is denied? ❑ Yes ❑ No

Prescription

Medication	Strength	Directions	Quantity	Refills
❑ Ingrezza®	❑ Titration Starter Pack	Take 1 capsule (40mg) orally once daily for 7 days then take 1 capsule (80mg) orally once daily thereafter	#1 pack	0 refills
	❑ 40mg capsule ❑ 60mg capsule ❑ 80mg capsule	Take 1 capsule orally once daily	#30	

Is patient new to this therapy: ❑ YES ❑ NO | **Ship to:** ❑ Patient ❑ Office ❑ Other | **Needs by Date:** ____________

Prescriber Data

Prescriber Name: ______________________________

DEA#: ______________________ NPI: ______________

Practice Name: ______________________________

Contact: ____________________ Preferred Method: ❑ Phone ❑ Fax ❑ Email

Address: ______________________________

Phone: ______________________________ Fax: ______________

City: ____________________ State: ______________ Zip: ______________

Email: ______________________________

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: ______________________________ Date: ______________

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right.