



Ingrezza® Enrollment Form

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-____ 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
<input type="checkbox"/> Ingrezza®	<input type="checkbox"/> 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
	<input type="checkbox"/> 40mg capsule <input type="checkbox"/> 60mg capsule <input type="checkbox"/> 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: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy 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 Value Specialty 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.