Movement Disorders Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
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: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
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:
Allergies: _____ Height: _____in/cm Weight: _____lb/kg

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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 6 mg by mouth twice a day during Week 1 ☐ Administer 9 mg by mouth twice a day during Week 2 ☐ Administer 12 mg by mouth twice a day during Week 3 ☐ Administer 15 mg by mouth twice a day during Week 4 ☐ Other _____	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. ☐ Other _____	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 **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as 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: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

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.