Movement Disorders Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-866-215-9855

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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____ _____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____ _____

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Austedo (initial prescription)	☐ 6 mg ☐ 9 mg ☐ 12 mg	☐ Administer 6 mg by mouth twice a day. Increase dose by 6 mg per day every week as needed to control symptoms. Maximum daily dose not to exceed 48 mg/day.	Quantity: 30-day supply Refills: 0
☐ Austedo (maintenance prescription)	☐ 6 mg ☐ 9 mg ☐ 12 mg	☐ Administer 6 mg by mouth twice a day. Increase dose by 6 mg per day every week as needed to control symptoms. Maximum daily dose not to exceed 48 mg/day.	Quantity: _____ Refills:_____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____**Date:** _____	**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.

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 XR Initial Titration	Titration Kit ***	☐ Administer 12 mg by mouth once a day during Week 1, 18 mg by mouth once a day during Week 2, 24 mg by mouth once a day during Week 3, and 30 mg by mouth once a day during Week 4 *** Titration Kit contents: (Weeks 1 and 2 Blister Pack contains seven 12 mg tablets taken during Week 1; and contains seven 6 mg tablets and seven 12 mg tablets taken during Week 2. Weeks 3 and 4 Blister Pack contains seven 24 mg tablets taken during Week 3; and contains seven 6mg tablets and seven 24 mg tablets taken during Week 4.)	Quantity: 1 kit Refills: 0
☐ Austedo XR Maintenance	☐ 6 mg ☐ 12 mg ☐ 24 mg ☐ 30 mg ☐ 36 mg ☐ 42 mg ☐ 48 mg	Titrate weekly by 6 mg per day to reach the dose selected below: ☐ Administer 24 mg by mouth once a day ☐ Administer 30 mg by mouth once a day ☐ Administer 36 mg by mouth once a day ☐ Administer 42 mg by mouth once a day ☐ Administer 48 mg by mouth once a day	Quantity: _____ Refills:_____
☐ Dichlorphenamide	☐ 50 mg	☐ Take ___ tablet(s) by mouth _____ daily. ☐ Other _____	Quantity: _____ Refills:_____
☐ Ingrezza (initial prescription)	☐ Initiation Pack *** ☐ 40 mg ☐ 60 mg ☐ 80 mg	☐ Administer 40 mg by mouth once a day. After one week increase the dose by 20 mg every two weeks as needed to control symptoms. Maximum daily dose not to exceed 80 mg per day. ☐ Other _____ *** Initiation Pack contents: 28-day blister pack contains 7 x 40 mg tablets and 21 x 80 mg tablets	Quantity: 30-day supply Refills: 0
☐ Ingrezza (maintenance prescription)	☐ 40 mg ☐ 60 mg ☐ 80 mg	☐ Administer 40 mg by mouth once a day ☐ Administer 60 mg by mouth once a day ☐ Administer 80 mg by mouth once a day ☐ Other _____	Quantity: _____ Refills:_____
☐ Ingrezza Sprinkle (initial prescription)	☐ 40 mg ☐ 60 mg ☐ 80 mg	☐ Administer 40 mg by mouth once a day. After one week increase the dose by 20 mg every two weeks as needed to control symptoms. Maximum daily dose not to exceed 80 mg per day. ☐ Other _____	Quantity: 30-day supply Refills: 0
☐ Ingrezza Sprinkle (maintenance prescription)	☐ 40 mg ☐ 60 mg ☐ 80 mg	☐ Administer 40 mg by mouth once a day ☐ Administer 60 mg by mouth once a day ☐ Administer 80 mg by mouth once a day ☐ Other _____	Quantity: _____ Refills:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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Prescriber's Signature: _____Date: _____	**Prescriber's Signature: _____Date: _____**

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