



ADVANCED PHARMACY SOLUTIONS

INGREZZA REFERRAL FORM

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Today's Date _____

Date Needed _____



- Phone Order
- Ship to Patient:
- Home Work
- Ship to:
- Physician Office
- Nurse / Training
- APS Pharmacy

Patient Name _____ Date of Birth _____ Male Female

Address _____ Apt # _____ City _____ State _____ Zip _____

Telephone _____ Cell _____ SSN _____ Email _____

Allergies _____ Comorbidities _____

Current Medications (if necessary, please fax a complete list) _____

Primary Insurance _____ ID# _____ Group # _____

Insured's Name _____ Employer _____

City _____ State _____ Phone _____ Please attach patient's insurance cards

ICD-10 Diagnosis Code: G24.01 Tardive Dyskinesia Other _____ Weight _____ BSA _____ m²

Allergies _____ Comorbidities _____

Patient currently on therapy? Yes No

Current medications patient (including OTC) with dosage and direction (or fax medication) _____

PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Medication	Directions	Quantity	Refills
Ingrezza® (valbenazine) capsules	Induction Dose: 40 mg by mouth once daily x 7 days then increase to 80 mg daily Other: _____	60 _____	1 2 3 4
	Maintenance Dose: 80 mg by mouth once daily 40 mg by mouth once daily	30	# Refills

Please attach the following: **Most Recent Progress Notes**
Abnormal Involuntary Movement Scale (AIMS) Dyskinesia Total Score

Thank you!

Prescriber's Name / Practice _____ Office Contact _____

Address _____ Suite# _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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