ADVANCED PHARMACY SOLUTIONS

INGREZZA REFERRAL FORM

26611 Cabot Road Suite B | Laguna Hills CA 92653
Ph 949-348-7900 | Toll Free 800-464-7736 | Fax 949-348-7920
NPI# 1922103142 NABP# 0547185
info@aps-rx.net APS-rx.net

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________________________ Member ID ______________

RxBIN ______________ RxPCN ______________ RxGrp ______________

Member Services Phone Number ______________ Provider Services Phone Number ______________

ICD-10 Diagnosis Code: Tardive Dyskinesia ☐ Other ____________ Weight __________ BSA __________m^2

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 ______ # Refills
	Maintenance Dose: 80 mg by mouth once daily 40 mg by mouth once daily	30	

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**______________

LEGAL NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. This prescription may be filled at a pharmacy of the patient's choice.

Please fax completed referral form to
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.