MOVEMENT DISORDERS REFERRAL FORM (A-I)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City		State	ZIP
Email	Home Phone		Work Phone		Cell Phone
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)		Alt Contact Email			Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email		Office Phone	Office Fax	
Practice / Facility Name		Prescriber Name / Specialty		
Address		City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date	Date of Next Blood Work
Other/Concomitant Medications (please list)	Patient Height (cm/in): Weight (kg/lbs):	Date Obtained:
Allergies ☐ NKDA ☐ Drug Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)		

ICD-10 Code
☐ G10: Huntington's Disease
☐ G20: Parkinson's Disease
☐ G24.01: Tardive Dyskinesia
☐ Other Code: _____ Description: _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Austedo	☐ 6 mg Tablet ☐ 9 mg Tablet ☐ 12 mg Tablet (Note: For titration dosing, select all 3 strengths & appropriate quantity will be dispensed)	☐ INITIAL TITRATION – Tardive Dyskinesia • 12 mg/day (6 mg BID) x Week 1 • 18 mg/day (9 mg BID) x Week 2 • 24 mg/day (12 mg BID) x Week 3 • 30 mg/day (15 mg BID) x Week 4	QS	0
		☐ INITIAL TITRATION – Huntington's Disease Chorea • 6 mg/day x Week 1 • 12 mg/day (6 mg BID) x Week 2 • 18 mg/day (9 mg BID) x Week 3 • 24 mg/day (12 mg BID) x Week 4	QS	0
		CONTINUING & SAMPLED PATIENTS (TD & HD CHOREA) Titrate weekly by 6 mg/day from current dose of _____ mg/day to reach the dose selected below (select one): ☐ 24 mg/day (12 mg BID) ☐ 30 mg/day (15 mg BID) ☐ 36 mg/day (18 mg BID) ☐ 42 mg/day (21 mg BID) ☐ 48 mg/day (24 mg BID) OR ☐ Other Rx Sig: _____		
☐ Ingrezza	☐ 40 mg Capsule ☐ 60 mg Capsule ☐ 80 mg Capsule	INITIAL DOSE: ☐ Initial Rx with 80 mg Maintenance Dose 40 mg by mouth once daily x7 days, then 80 mg by mouth once daily x 23 days	#7 (40 mg) #23 (80 mg)	0
		MAINTENANCE DOSE: ☐ 40 mg by mouth once daily ☐ 60 mg by mouth once daily ☐ 80 mg by mouth once daily	#30 #30 #30	
		☐ Other Rx Sig: _____		

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV.072423

MOVEMENT DISORDERS REFERRAL FORM (J-Z)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date	Date of Next Blood Work
Other/Concomitant Medications (please list)	Patient Height (cm/in): Weight (kg/lbs):	Date Obtained:
Allergies ☐ NKDA ☐ Drug Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)		
ICD-10 Code ☐ G10: Huntington's Disease ☐ G20: Parkinson's Disease ☐ G24.01: Tardive Dyskinesia ☐ Other Code: _____ Description: _____		

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Kynmobi	☐ Titration Kit	Contact Kynmobi Kynnect at 1-844-596-6624 for more information.	0	0
	MAINTENANCE DOSE: ☐ 10 mg SL film ☐ 15 mg SL film ☐ 20 mg SL film ☐ 25 mg SL film ☐ 30 mg SL film	Place 1 film under the tongue, do not exceed _____ doses per day.	30-Day	
☐ Neuromuscular Blocker / Botulinum Toxins	☐ Botox ☐ 50 U ☐ 100 U ☐ 200 U ☐ Dysport ☐ 300 U ☐ 500 U ☐ Myobloc ☐ 2500 U ☐ 5000 U ☐ 10000 U ☐ Xeomin ☐ 50 U ☐ 100 U ☐ 200 U	DIRECTIONS FOR USE (include frequency, minimum is 12 weeks; to be given by a prescriber in office, unless otherwise specified): _____ _____ _____ Location for Injection(s) – (specify site(s) and number of units per site): _____ _____	_____ Vials	
☐ Tetrabenazine	☐ 12.5 mg Tablet ☐ 25 mg Tablet ☐ Patient has Genotype for CYP2D6	☐ INITIATION/TITRATION DOSE Week 1: _____ Week 2: _____ Week 3: _____ Week 4: _____	QS	0
		MAINTENANCE DOSE: Sig: _____		

_____ _____ _____ _____

Prescriber Signature | Date | Supervising Physician Signature (where required by state law) | Date

_____ _____ _____

DAW (Dispense as Written) | Date | Brand Necessary (must handwrite)

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

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