MOVEMENT DISORDERS REFERRAL FORM (A-I)

PHONE 888.370.1724 | FAX 877.645.7514



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	F	rimary Lar	iguage	
Address			City			Stat	e		ZIP	
Email	Home Phone			Work Pho	one			Cell Pho	ne	
Primary Contact Method (check one)) Cell Phone Home Pho	one 🛛 Work Phone	e 🗆 Tex	xt 🗆 Email	🗆 Pri	imary Caregiver 🛛 🗆 D	о пот с	ONTACT		
Primary Caregiver/Alt Contact Name	(If applicable)	Alt Conta	ct Email				A	Alt Contact	Phone	
PRESCRIBER INFORMATION							, i			
Name of Contact Sending Referral		Title			Prefe	erred Contact Method (check on	ie) 🗆 Em	ail 🗆 Phone	🗆 Fax
Referral Contact Email				Office Phone			Office	e Fax		
Practice / Facility Name				Prescriber Na	ame / S	Specialty				
Address			Ci	ty				State	ZIP	
Prescriber State License #	DEA #		N	PI #			Medica	id UPIN #	· ·	
	* Please include	e a copy of th	e fron	t and bacl	k of I	insurance card *				
CLINICAL INFORMATION - F	lease include applicable	e clinical chart r	notes							
Patient New to Therapy 🗆 Naïve/New	v Start 🛛 Therapy Restart 🗆	Existing Treatment	т	herapy Start D	ate		Date o	f Next Bloo	d Work	
Other/Concomitant Medications (plea	ase list)		F	Patient Height (cm/in)): Weight (kg/	lbs):	Dat	e Obtained:	
Allergies NKDA Drug Allergie	es (please list)									
Ship to Address 🗆 Home 🗆 Preso	riber's Office 🛛 Other (please	e list)								
ICD-10 Code G10: Huntington's Disease G24.01: Tardive Dyskinesia G20: Parkinson's Disease Gther 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
	☐ 6 mg Tablet ☐ 9 mg Tablet ☐ 12 mg Tablet (Note: For titration dosing, select all 3 strengths & appropriate quantity will be dispensed)	 12 mg/day 18 mg/day 24 mg/day 30 mg/day 	 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 TI 6 mg/day 12 mg/day 18 mg/day 	□ 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	o	
		Titrate week selected bel 24 mg/day 30 mg/day 36 mg/day 42 mg/day	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) 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	40 mg by m	vith 80 n outh onc	ng Maintenance e daily x7 days e daily x 23 da	, then				#7 (40 mg) #23 (80 mg)	0
		□ 40 mg by □ 60 mg by	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	□ 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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.

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MOVEMENT DISORDERS REFERRAL FORM (J-Z)

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PATIENT INFORMATION										
Last Name	First Name	DOB		Gender 🗆 M	□F	Last 4 SSN		Primary La	nguage	
Address		·	City				State		ZIP	
Email	Home Phone			Work Pho	one			Cell Pho	one	
Primary Contact Method (check one) Cell Phone Home Ph	one 🛛 Work Phon	e 🗆 Te	ext 🗆 Email	🗆 Pri	mary Caregiver		OT CONTACT		
Primary Caregiver/Alt Contact Name	(If applicable)	Alt Conta	ict Emai	il				Alt Contac	t Phone	
PRESCRIBER INFORMATION	l -									
Name of Contact Sending Referral		Title			Prefe	erred Contact Met	hod (chec	k one) 🗆 Em	nail 🗆 Phone	🗆 Fax
Referral Contact Email		I		Office Phone			0	ffice Fax		
Practice / Facility Name				Prescriber Na	ame / S	Specialty				
Address			0	City				State	ZI	P
Prescriber State License #	DEA #		1	NPI #			Me	dicaid UPIN #		
	* Please includ	le a copy of th	e froi	nt and back	k of i	insurance ca	ard *			
CLINICAL INFORMATION - F	Please include applicab	e clinical chart	notes							
Patient New to Therapy 🗆 Naïve/New	v Start 🛛 Therapy Restart	□ Existing Treatment		Therapy Start D	ate		Dat	te of Next Blo	od Work	
Other/Concomitant Medications (plea	ase list)			Patient Height (cm/in)): Weigh	t (kg/lbs):	Da	te Obtained:	
Allergies DKDA Drug Allergies (please list)										
Ship to Address	riber's Office 🛛 Other (pleas	e list)								
ICD-10 Code G10: Huntington's Disease G24.01: Tardive Dyskinesia										
I G G C : Parkinson's Disease I G C : Code: Description:										
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MEDICATION	DOSE	DIRECTION							QTY	REFILLS
□ Kynmobi	Titration Kit			vnnect at 1-844-	596-6	624 for more info	rmation.		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.							
□ Neuromuscular Blocker / Botulinum Toxins □ Botox □ 100 U □ 200 U □ 100 U □ 200 U □ 500 U □						e given by a				
	□ Myobloc □ 2500 U □ 5000 U □ 1000 □ Xeomin □ 50 U □ 100 U □ 200 U		Injectio	on(s) - (specify s	site(s)	and number of ur	number of units per site):			
Tetrabenazine	□ 12.5 mg Tablet □ 25 mg Tablet □ Patient has Genotype for C ^v	Week 1: Week 2:	Week 2: Week 3:				QS	0		
		MAINTENAI Sig:	ICE DO	SE:						

Prescriber Signature	Date	Supervising Physician Signature (where required by state law)	Date
DAW (Dispense as Written)	Date	Brand Necessary (must handwrite)	

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