

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	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: _____		

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.

Amber Enterprises, Inc., dba Amber Specialty Pharmacy ©2026

REV10/426

MOVEMENT DISORDERS REFERRAL FORM (J-Z)

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	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
☐ 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: MAINTENANCE DOSE: Sig:	QS	0

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.

Amber Enterprises, Inc., dba Amber Specialty Pharmacy ©2026

REV10/426