PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

INGREZZA ORDER FORM

Ship to: ☐ Patient ☐ Physician ☐ Other

Patient Information

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____ Alternate Contact Info: _____

Allergies: _____ E-Mail: _____

PATIENT CONSENT (Patient, please initial)

By initialing in the space provided, you are agreeing to receive text messages sent by Premier Pharmacy Services' via automated technology to the mobile phone number provided. Message and data rates may apply. You may text STOP to 97595 to opt-out (you will be sent a confirmation message) or call 800-540-4700 x625

_____ Initial

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS

Clinical

Include patient chart notes and AIMS Exam results with order form

Diagnosis:
☐ G24.01 Tardive Dyskinesia
☐ Other Diagnosis: _____

Date of diagnosis: _____

AIMS Exam result: ☐ Positive ☐ Negative

Current antipsychotic: _____

Tried and Failed History

☐ Metoclopramide ☐ Austedo ☐ Benzodiazepines: _____ ☐ Other: _____

☐ Amantadine ☐ Xenazine ☐ 2nd generation antipsychotic: _____ _____

Duration: _____ Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated
☐ Side effects: _____ Other: _____

Prescription Information

PRESCRIPTION FOR INGREZZA (valbenazine) CAPSULES: Check one box below		Quantity	Refills
☐ Ingrezza initiation pack with 80mg maintenance	**Initial Dose:** Take 40mg by mouth every day for 7days Then take 80mg by mouth every day for 23 days **Maintenance Dose:** Take 80mg by mouth every day	1 pack (7 x 40mg + 21 x 80mg) 30	None _____
☐ Ingrezza 40mg	Take 40mg by mouth every day	30	_____
☐ Ingrezza 60mg	Take 60mg by mouth every day	30	_____
☐ Ingrezza 80mg	Take 80mg by mouth every day	30	_____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ ☐ **Dispense as written (DAW) Date:** _____/_____/_____