

Movement Disorders Enrollment Form



Fax Referral To: 1-800-323-2445

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-866-215-9855

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ City, State, ZIP Code: _____

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ G24.01 Tardive Dyskinesia (TD)

☐ G10 Huntington's Chorea (HD)

☐ G72.3 Periodic Paralysis

☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____

Height: _____ in/cm

Weight: _____ lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Austedo (initial prescription)	☐ 6 mg ☐ 9 mg ☐ 12 mg	☐ Administer 6 mg by mouth twice a day. Increase dose by 6 mg per day every week as needed to control symptoms. Maximum daily dose not to exceed 48 mg/day.	Quantity: 30-day supply Refills: 0
☐ Austedo (maintenance prescription)	☐ 6 mg ☐ 9 mg ☐ 12 mg	☐ Administer 6 mg by mouth twice a day. Increase dose by 6 mg per day every week as needed to control symptoms. Maximum daily dose not to exceed 48 mg/day.	Quantity: _____ Refills: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

Movement Disorders Enrollment Form

Please Complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Austedo XR Initial Titration	Titration Kit ***	☐ Administer 12 mg by mouth once a day during Week 1, 18 mg by mouth once a day during Week 2, 24 mg by mouth once a day during Week 3, and 30 mg by mouth once a day during Week 4 *** Titration Kit contents: (Weeks 1 and 2 Blister Pack contains seven 12 mg tablets taken during Week 1; and contains seven 6 mg tablets and seven 12 mg tablets taken during Week 2. Weeks 3 and 4 Blister Pack contains seven 24 mg tablets taken during Week 3; and contains seven 6mg tablets and seven 24 mg tablets taken during Week 4.)	Quantity: 1 kit Refills: 0
☐ Austedo XR Maintenance	☐ 6 mg ☐ 12 mg ☐ 24 mg ☐ 30 mg ☐ 36 mg ☐ 42 mg ☐ 48 mg	Titrate weekly by 6 mg per day to reach the dose selected below: ☐ Administer 24 mg by mouth once a day ☐ Administer 30 mg by mouth once a day ☐ Administer 36 mg by mouth once a day ☐ Administer 42 mg by mouth once a day ☐ Administer 48 mg by mouth once a day	Quantity: _____ Refills: _____
☐ Dichlorphenamide	☐ 50 mg	☐ Take ____ tablet(s) by mouth _____ daily. ☐ Other _____	Quantity: _____ Refills: _____
☐ Ingrezza (initial prescription)	☐ Initiation Pack *** ☐ 40 mg ☐ 60 mg ☐ 80 mg	☐ Administer 40 mg by mouth once a day. After one week increase the dose by 20 mg every two weeks as needed to control symptoms. Maximum daily dose not to exceed 80 mg per day. ☐ Other _____ *** Initiation Pack contents: 28-day blister pack contains 7 x 40 mg tablets and 21 x 80 mg tablets	Quantity: 30-day supply Refills: 0
☐ Ingrezza (maintenance prescription)	☐ 40 mg ☐ 60 mg ☐ 80 mg	☐ Administer 40 mg by mouth once a day ☐ Administer 60 mg by mouth once a day ☐ Administer 80 mg by mouth once a day ☐ Other _____	Quantity: _____ Refills: _____
☐ Ingrezza Sprinkle (initial prescription)	☐ 40 mg ☐ 60 mg ☐ 80 mg	☐ Administer 40 mg by mouth once a day. After one week increase the dose by 20 mg every two weeks as needed to control symptoms. Maximum daily dose not to exceed 80 mg per day. ☐ Other _____	Quantity: 30-day supply Refills: 0
☐ Ingrezza Sprinkle (maintenance prescription)	☐ 40 mg ☐ 60 mg ☐ 80 mg	☐ Administer 40 mg by mouth once a day ☐ Administer 60 mg by mouth once a day ☐ Administer 80 mg by mouth once a day ☐ Other _____	Quantity: _____ Refills: _____

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

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