# 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<br>☐ 9 mg Tablet<br>☐ 12 mg Tablet<br><br>(Note: For titration dosing, select all 3 strengths & appropriate quantity will be dispensed) | ☐ INITIAL TITRATION – Tardive Dyskinesia<br>• 12 mg/day (6 mg BID) x Week 1<br>• 18 mg/day (9 mg BID) x Week 2<br>• 24 mg/day (12 mg BID) x Week 3<br>• 30 mg/day (15 mg BID) x Week 4 | QS | 0 |
| | | ☐ INITIAL TITRATION – Huntington's Disease Chorea<br>• 6 mg/day x Week 1<br>• 12 mg/day (6 mg BID) x Week 2<br>• 18 mg/day (9 mg BID) x Week 3<br>• 24 mg/day (12 mg BID) x Week 4 | QS | 0 |
| | | CONTINUING & SAMPLED PATIENTS (TD & HD CHOREA)<br>Titrate weekly by 6 mg/day from current dose of _____ mg/day to reach the dose selected below (select one):<br>☐ 24 mg/day (12 mg BID)<br>☐ 30 mg/day (15 mg BID)<br>☐ 36 mg/day (18 mg BID)<br>☐ 42 mg/day (21 mg BID)<br>☐ 48 mg/day (24 mg BID)<br>OR<br>☐ Other Rx Sig: _____ | | |
| ☐ Ingrezza | ☐ 40 mg Capsule<br>☐ 60 mg Capsule<br>☐ 80 mg Capsule | INITIAL DOSE:<br>☐ Initial Rx with 80 mg Maintenance Dose<br>40 mg by mouth once daily x7 days, then<br>80 mg by mouth once daily x 23 days | #7 (40 mg)<br>#23 (80 mg) | 0 |
| | | MAINTENANCE DOSE:<br>☐ 40 mg by mouth once daily<br>☐ 60 mg by mouth once daily<br>☐ 80 mg by mouth once daily | #30<br>#30<br>#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.072224

# MOVEMENT DISORDERS REFERRAL FORM (J-Z)

**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 |
|---|---|---|---|---|
| ☐ Neuromuscular Blocker / Botulinum Toxins | ☐ Botox<br>☐ 50 U ☐ 100 U ☐ 200 U<br>☐ Dysport<br>☐ 300 U ☐ 500 U<br>☐ Myobloc<br>☐ 2500 U ☐ 5000 U ☐ 10000 U<br>☐ Xeomin<br>☐ 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):<br>_____<br>_____<br>_____<br>Location for Injection(s) – (specify site(s) and number of units per site):<br>_____<br>_____ | _____ Vials | |
| ☐ Tetrabenazine | ☐ 12.5 mg Tablet<br>☐ 25 mg Tablet<br><br>☐ Patient has Genotype for CYP2D6 | ☐ INITIATION/TITRATION DOSE<br>Week 1: _____<br>Week 2: _____<br>Week 3: _____<br>Week 4: _____<br>MAINTENANCE DOSE:<br>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.*



REV.072224