Phone: 417-719-4510
Fax: 417-893-3908
specialty.alpspharmacy.com

Ingrezza

PATIENT INFORMATION

Patient Name: ______
Address: ______
City, State, ZIP: ______
Home Phone: ______ Alternate Phone: ______
Caregiver: ______ Email: ______
DOB: ______ Social Security#: ______
Gender: ☐ Male ☐ Female Comorbidities: ______
Height: ______ Weight: ______ Allergies: ______

PRESCRIBER INFORMATION

Prescriber's Name: ______
Address: ______
City, State, ZIP: ______
Phone: ______ Fax: ______
NPI: ______ Tax ID: ______
DEA: ______
Office Contact: ______ Phone: ______
Contact Email: ______

INSURANCE INFORMATION

Please fax a copy of patients' insurance cards (prescription and medical, FRONT and BACK) including any secondary insurance.

CLINICAL INFORMATION (Please fax all pertinent clinical and lab information and/or attach separate sheet if needed.)

Diagnosis: ☐ **G24.01 Tardive Dyskinesia** ☐ **Other:** ______

PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
☐ Ingrezza® (valbenazine) capsules	Induction Dose: ☐ 40 mg by mouth once daily x 7 days then increase to 80 mg daily ☐ Other: ______	______	Ø
	Maintenance Dose: ☐ 80 mg by mouth once daily ☐ 40 mg by mouth once daily	☐ 30 day supply	______
☐ Other:	______	______	______

PRESCRIPTION DELIVERY

☐ Patient's Home ☐ Physician's Office ☐ Patient Will Pick Up in Pharmacy Date Issued: ______ Needs by Date: ______

PRESCRIBER AUTHORIZATION

I authorize Alps Pharmacy, including it's representatives and subcontractors, to act as my agent to initiate and execute the insurance prior authorization, patient assistance, and nursing programs. If Alps Pharmacy is unable to fulfill this prescription, I authorize Alps Pharmacy to forward this information and data related to the coverage of this prescription to another pharmacy.

Prescriber's Signature: ______ Date: ______
PRODUCT SUBSTITUTION PERMITTED

Prescriber's Signature: ______ Date: ______
Dispense As Written

CONFIDENTIALITY NOTICE

The information contained in this for is intended only for the use of individual or entity named. It contains confidential information, legally privileged, that may be protected health information under federal and state laws. If you are not the intended recipient, you are hereby notified that any dissemination, copying, or distribution of this communication is strictly prohibited. If you have received this form in error, please notify the sender and immediately destroy this communication.

Disclaimer: Alps can accept only original prescription drug orders from patients, and faxed prescriptions can be accepted only from the prescribing practitioners.