

Ship to:  Patient  Physician  Other

<b>Patient Information</b>	Patient Name: _____ DOB: _____ SSN: _____
	Address: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ Alt Phone: _____
	Email: _____
	Alternate Contact Info: _____
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Allergies: _____

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

<b>Medical Justification</b>	Diagnosis: _____ Date of Diagnosis: _____ <input type="checkbox"/> G240 Tardive Dyskinesia <input type="checkbox"/> F31 Bipolar Disorder <input type="checkbox"/> F33 Major Depressive Disorder <input type="checkbox"/> G25.5 Chorea <input type="checkbox"/> F20.9 Schizophrenia <input type="checkbox"/> Other: _____	Tried and Failed History: Medication (antipsychotic): _____ Date/Duration: _____ Response: <input type="checkbox"/> Intolerant <input type="checkbox"/> Ineffective <input type="checkbox"/> Contraindicated <input type="checkbox"/> Side effects <input type="checkbox"/> Other: _____
	Kidney Function: GFR _____ or CrCl _____ Child-Pugh Score: _____	

Prescription Information	Medication	Strength	Directions	Quantity	Refills
	<input type="checkbox"/> Auvelity ER	<input type="checkbox"/> 45mg/105mg tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily for three days then 1 tablet by mouth twice a day at least 8 hours apart (max 2 tabs/24hrs) <input type="checkbox"/> Other: _____	30 tablets	_____
	<input type="checkbox"/> Caplyta	<input type="checkbox"/> 10.5mg capsule <input type="checkbox"/> 21mg capsule <input type="checkbox"/> 42mg capsule	<input type="checkbox"/> Take 42mg my mouth once daily <input type="checkbox"/> Other: _____	30 capsules	_____
	<input type="checkbox"/> Ingrezza	<input type="checkbox"/> 4-Week Initiation Pack <input type="checkbox"/> 40mg capsule <input type="checkbox"/> 60mg capsule <input type="checkbox"/> 80mg capsule	<input type="checkbox"/> <b>Initial Dose:</b> Take 40mg by mouth once daily for 1 week, then 80mg by mouth once daily thereafter <input type="checkbox"/> <b>Maintenance Dose:</b> Take 80mg by mouth daily <input type="checkbox"/> Other: _____	28 capsules 30 capsules	None _____
	<input type="checkbox"/> Lybalvi	<input type="checkbox"/> 5/10mg tablet <input type="checkbox"/> 10/10mg tablet <input type="checkbox"/> 15/10mg tablet <input type="checkbox"/> 20/10mg tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Other: _____	30 tablets	_____
	<input type="checkbox"/> Rexulti	<input type="checkbox"/> 0.25mg tablet <input type="checkbox"/> 0.5mg tablet <input type="checkbox"/> 1mg tablet <input type="checkbox"/> 2mg tablet <input type="checkbox"/> 3mg tablet <input type="checkbox"/> 4mg tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Other: _____	30 tablets	_____
	<input type="checkbox"/> Vraylar	<input type="checkbox"/> 1.5mg capsule <input type="checkbox"/> 3mg capsule <input type="checkbox"/> 4.5mg capsule <input type="checkbox"/> 6mg capsule	<input type="checkbox"/> Take 1 capsule by mouth once daily <input type="checkbox"/> Other: _____	30 capsules	_____

<b>Prescription Information</b>	<b>AUSTEDO</b>		<b>AUSTEDO XR</b>	
	<input type="checkbox"/> <b>INITIAL TITRATION – AUSTEDO</b>		<input type="checkbox"/> <b>INITIAL TITRATION – AUSTEDO XR</b>	
	<ul style="list-style-type: none"> <li>• 12mg/day: 6mg PO BID for week 1</li> <li>• 18mg/day: 9mg PO BID for week 2</li> <li>• 24mg/day: 12mg PO BID for week 3</li> <li>• 30mg/day: 15mg (9mg + 6mg) PO BID for week 4</li> </ul> Quantity: QS with combination of 6mg, 9mg, and 12mg tablets to provide appropriate dosing No Refills		<ul style="list-style-type: none"> <li>• 12mg PO QD for week 1</li> <li>• 18mg (12mg + 6mg) PO QD for week 2</li> <li>• 24mg PO QD for week 3</li> <li>• 30mg (24mg + 6mg) PO QD for week 4</li> </ul> Quantity: QS with combination of 6mg, 9mg, and 12mg tablets to provide appropriate dosing No Refills	
	<b>MAINTENANCE DOSING OR SWITCHING FROM TETRABENAZINE – AUSTEDO</b>		<b>MAINTENANCE DOSING OR SWITCHING FROM TETRABENAZINE – AUSTEDO XR</b>	
<input type="checkbox"/> 24mg/day (12mg PO BID) <input type="checkbox"/> 30mg/day (15mg PO BID) <input type="checkbox"/> 36mg/day (18mg PO BID) <input type="checkbox"/> 42mg/day (21mg PO BID) <input type="checkbox"/> 48mg/day (24mg PO BID) <input type="checkbox"/> Other: _____		<input type="checkbox"/> 24mg PO QD <input type="checkbox"/> 30mg PO QD <input type="checkbox"/> 36mg PO QD <input type="checkbox"/> 42mg PO QD <input type="checkbox"/> 48mg PO QD <input type="checkbox"/> Other: _____		
Quantity: QS with combination of 6mg, 9mg, and 12mg tablets to provide appropriate dosing		Quantity: QS with combination of 6mg, 12mg, and 24mg tablets to provide appropriate dosing		
Days Supply: _____ Refills: _____		Days Supply: _____ Refills: _____		

<b>Prescriber Information</b>	<b>PRIOR AUTHORIZATION</b>			
	Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____			
	Address: _____			
	City: _____ Zip: _____ Tel: _____ Fax: _____			
Contact Person: _____ E-Mail: _____				
<b>PRESCRIBER SIGNATURE</b> (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 Polaris Specialty 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: _____		<input type="checkbox"/> <b>Dispense as written (DAW) Date:</b> ____/____/____		
IMPORTANT NOTICE: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.				

*Intentionally left blank*