POLARIS SPECIALTY Rx

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Polaris Specialty Pharmacy
410 Cloverleaf Drive
Baldwin Park, CA 91706
NPI: 1053486795

INGREZZA ORDER FORM

Ship to: ☐ Patient ☐ Physician ☐ Other: ______________________________

Patient Information

Patient Name: ______________________________ DOB: ______________ SSN: ______________

Address: ______________________________

City: ______________________________ State: ____________ Zip: ______________

Phone: ______________________________ Alt Phone: ______________________________

Email: ______________________________

Alternate Contact Info: ______________________________

Allergies: ______________________________

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

Clinical Information

Include patient chart notes and AIMS Exam results with order form

Diagnosis:
☐ G24.01 Tardive Dyskinesia

Date of diagnosis: ______________

☐ Other Diagnosis: ______________________________

AIMS Exam result: ☐ Positive ☐ Negative

Current antipsychotic: ______________________________

Tried and Failed History Must be completed for all patients

☐ 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	1 pack (7 x 40mg + 21 x 80mg)	None
		Maintenance Dose: Take 80mg by mouth every day	30	________
☐	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 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: ______________________________ ☐ **Dispense as written (DAW) Date:** ______/______/______

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