MATRIXVIP

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**Questions?** E-mail us at **INFO@MATRIX-PHARMACY.COM** or Call **(412) 586-4545**. We are here to assist you!

# INGREZZA® ENROLLMENT FORM

## PATIENT INFORMATION & DEMOGRAPHICS

**ORDER DATE:** _____ **APPOINTMENT DATE (if known):** _____

**FIRST NAME:** _____ **LAST NAME:** _____

**DOB:** _____ ☐ **Female** ☐ **Male** **PHONE:** _____

**ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**INSURANCE COMPANY:** _____ **ID#:** _____

**GROUP#:** _____ **EMERGENCY CONTACT:** _____

## PRESCRIPTION INFORMATION

**DIAGNOSIS:** ☐ **G24.0____ (Tardive Dyskinesia)**

| DRUG | STRENGTH | | |
|---|---|---|---|
| ☐ **Ingrezza® capsules** | ☐ **40mg** | ☐ **60mg** | ☐ **80mg** |
| ☐ _____ | _____ | | |
| ☐ _____ | _____ | | |

**Directions: Take _____ Ingrezza capsule(s) by mouth once daily**

**Quantity: _____ Refills: _____**

## PRESCRIBER INFORMATION

**OFFICE/CLINIC NAME:** _____ **ATTN:** _____

**OFFICE ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**PHONE:** _____ **FAX:** _____

**PRESCRIBER NAME** _____

**NPI:** _____ **LICENSE:** _____ **DEA:** _____

**PRESCRIBER SIGNATURE:** _____ **DATE:** _____

(substitution permissible if applicable)

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

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