MATRIXVIP

MATRIX VIP PHARMACY
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Questions? E-mail us at **INFO@MATRIX-PHARMACY.COM** or Call **(866) 410-3306**. We are here to assist you!

ORAL MOVEMENT DISORDER MEDICATIONS 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: ☐ **G10 (Huntington's Chorea)** ☐ **G24.0** ☐ **(Tardive Dyskinesia)**

DRUG	STRENGTH
☐ **AUSTEDO® tablets**	☐ **6mg** ☐ **9mg** ☐ **12mg**
Directions: Take ____ **tablets** ____ **times per day**	**Quantity:** ____ **Refills:** ____
☐ **INGREZZA® capsules**	☐ **40mg** ☐ **60mg** ☐ **80mg**
Directions: Take ____ **tablets** ____ **times per day**	**Quantity:** ____ **Refills:** ____
☐ **TETRABENAZINE tablets**	☐ **12.5mg** ☐ **25mg**
Directions: Take ____ **tablets** ____ **times per day**	**Quantity:** ____ **Refills:** ____
☐ _____	
Directions: _____	**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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