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INGREZZA® Prescription & Enrollment Form
Genoa Healthcare®



Order Date: _____ Appointment Date: _____
Last Name: _____ First Name: _____
Address: _____
City: _____ State/Zip: _____
Phone: _____ DOB: _____
Insurance Company: _____ ID #: _____
Group #: _____ Emergency Contact: _____

PRESCRIPTION INFORMATION

Diagnosis (ICD10): _____

☐ Tardive Dyskinesia ☐ Huntington's Disease Chorea ☐ Other: _____

Allergies: _____

INGREZZA® (valbenazine)

Capsules / Sprinkle

☐ 40 mg

SIG: _____

☐ 60 mg

SIG: _____

☐ 80 mg

SIG: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____

Office Address: _____

Phone: _____ Fax: _____

SIGNATURE

Prescriber Signature: _____ Date: _____

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