Note: This prescription is valid only if transmitted by facsimile from the prescriber's office. This form is not a valid prescription in Arizona or Virginia. Physician must attest that this is his/her legal signature (no stamps). Prescriber must comply with his/her state-specific requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable laws in your state.

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: _____

INGREZZA® PRESCRIPTION (twice daily formulation)

☐ INGREZZA® 40mg: Sig:_____ Quantity: _____ Refills #: _____

☐ INGREZZA® 60mg: Sig:_____ Quantity: _____ Refills #: _____

☐ INGREZZA® 80mg: Sig:_____ Quantity: _____ Refills #: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____

Office Address: _____

Phone: _____ Fax: _____

SIGNATURE

Prescriber Signature: _____ Date: _____

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