Tetrabenazine Treatment Form

Pharmacy Help: 800-496-6111

Fax completed form to: 800-540-1852

Complete the information below OR include copies of insurance cards

PATIENT INFORMATION

Name (Last, First): _____

Date of Birth: _____ Gender: M ☐ F ☐

_____
Address Apt#

_____
City State Zip

_____
Phone Cell Phone

_____
Best time to call Email

_____
Preferred Contact Person

_____
Phone Cell Phone

Ship to: (if different from above) ☐ Skilled Nursing Facility ☐ Hospital

☐ Other _____

_____
Facility Name (if applicable)

_____
Address

_____
City State Zip

_____
Phone Contact Person

_____
Special Shipping Instructions

INSURANCE INFORMATION

Name of Medical Plan: _____

Phone: _____

Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child

☐ Other: _____

_____
Cardholder Name Plan Number

_____
Group Number ID Number

SECONDARY INSURANCE

_____
Cardholder Name Plan Number

_____
Group Number ID Number

_____
Employer Phone

PRESCRIPTION INSURANCE

_____
Name of Prescription Plan Phone

_____
Rx BIN Rx PCN

_____
Rx ID # Group #

PRESCRIBER INFORMATION

Prescriber Name: _____
(First) (Last)

Specialty: ☐ Neurology ☐ Other: _____

Prescriber Address: _____

Prescriber Address #2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ NPI #: _____

Physician Office Contact: _____ Phone: _____

Rx Tetrabenazine Date: _____

☐ 12.5-mg tablets 30 Day Supply Quantity: _____ 90 Day Supply Quantity: _____

☐ 25-mg tablets 30 Day Supply Quantity: _____ 90 Day Supply Quantity: _____

Refills: _____

Titration schedule (per week)

Week 1: _____

Week 2: _____

Week 3: _____

Week 4: _____

ICD-10 Code:? ☐ G10 Huntington's Disease

Prescriber Signature: _____ Date: _____