Orsini Specialty Pharmacy

Fax: 877.819.2424 Phone: 800.691.0718

AUSTEDO (DEUTETRABENAZINE) PATIENT ENROLLMENT

1 PATIENT INFORMATION

☐ Please attach demographic information

(Please complete the following information)

Patient Name (First, MI, Last): ____________ DOB: ________ Gender: Male Female

Address: ____________ City: ____________ State: ______ Zip: ________

Patient Phone Number: ____________

Parent/Caregiver Name (First, MI, Last): ____________ Parent/Caregiver Phone Number: ____________

2 INSURANCE INFORMATION

☐ Please attach front and back of patient's insurance card, prescription card, and/or Medicaid card.

Primary Insurance Name: ____________

Primary Insurance ID: ____________

Insurance Phone Number: ____________

Policyholder Name: ____________

Secondary Insurance Name: ____________

Primary Insurance ID: ____________

Insurance Phone Number: ____________

Policyholder Name: ____________

3 CLINICAL INFORMATION

☐ Please fax clinical documentation to pharmacy along with referral form.

G24.01 Tardive Dyskinesia (TD) G10 Huntington's Chorea (HD) Other ICD-10 ____________

NKDA Drug Allergies ____________

Concurrent Medications: ____________

4 PRESCRIBER INFORMATION

Practice Name: ____________

Prescriber Name: ____________ Specialty: ____________ NPI: ____________

Address: ____________ City: ____________ State: ______ Zip: ________

Office Contact: ____________ Phone: ____________ Fax: ____________

5 PRESCRIPTION INFORMATION

Austedo 6 mg, 9 mg & 12 mg tablets

May Substitute Dispense as Written

☐ INITIAL TITRATION Rx

To reach 30 mg/day dose:

- 12 mg/day (6 mg BID) x Week 1
- 18 mg/day (9 mg BID) x Week 2
- 24 mg/day (12 mg BID) x Week 3
- 30 mg/day (15 mg BID) x Week 4

Qty: 28 days No Refills

☐ CONTINUING & SAMPLED PATIENTS

Titrate weekly by 6 mg/day from dose ________ mg/day to reach the dose selected below **(select one):**

☐ 36 mg/day (18 mg BID) - Dose selection following initial 4-week titration

☐ 42 mg/day (21 mg BID)

☐ 48 mg/day (24 mg BID)

Qty: 30 days Refills #: ____________

☐ Other Rx or Switch from Tetrabenazine* Sig: ____________ Quantity: ________ Refills #: ________

*Start at 50% of current TBZ dose

Physician's Signature ____________ Date of Signature ____________

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