Fax: 877.819.2424 **Phone:** 800.691.0718

Orsini Specialty Pharmacy

AUSTEDO® XR (DEUTETRABENAZINE) EXTENDED RELEASE PATIENT ENROLLMENT

1 PATIENT INFORMATION

(Please complete the following information)

☐ Please attach demographic 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 XR 6 mg, 12 mg & 24 mg tablets

◯ May Substitute ◯ Dispense as Written

☐ INITIAL TITRATION Rx

To reach 30 mg/day dose:

- 12 mg by mouth once daily x Week 1
- 18 mg (12 mg + 6 mg) by mouth once daily x Week 2
- 24 mg by mouth once daily x Week 3
- 30 mg (24 mg + 6 mg) by mouth once daily 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 by mouth once daily - Dose selection following initial 4-week titration

◯ 42 mg by mouth once daily

◯ 48 mg by mouth once daily

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 _____