

Send updates to: Fax: _____ Email: _____ Text: _____

Physician Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:
Office Contact:		Practice Name / Supervising MD:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:
Policyholder Name:	Policyholder DOB:	BIN: PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code: <input type="radio"/> Huntington's Disease (G10) <input type="radio"/> Other:	Has patient been previously treated for this condition? <input type="radio"/> Y <input type="radio"/> N
Prior failed medication (medication and duration of treatment/reason for d/c): <input type="radio"/>	
Patient currently on therapy? <input type="radio"/> Y <input type="radio"/> N Medication(s):	Will patient be stopping above medication before starting new therapy? <input type="radio"/> Y <input type="radio"/> N Discontinuation Date: / /
Is prescriber a Neurologist? If no, please include neurology consult if available <input type="radio"/> Other:	Number of relapses in past year: Last MRI date: / / Any MRI changes? <input type="radio"/> Y <input type="radio"/> N
Is patient pregnant, nursing or planning pregnancy? <input type="radio"/> Y <input type="radio"/> N <input type="radio"/> N/A	<input type="radio"/> Serum Creatine: <input type="radio"/> Creatinine Clearance:

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
<input type="radio"/> TETRABENAZINE® (Titration Dose)	<input type="radio"/> 12.5mg <input type="radio"/> 25mg	<input type="radio"/> Dose Titration: Week 1: _____ Week 2: _____ Week 3: _____ Week 4: _____		NO REFILLS
<input type="radio"/> TETRABENAZINE® (Maintenance Dose)	<input type="radio"/> 12.5mg <input type="radio"/> 25mg	<input type="radio"/> Maintenance Dose: _____ mg PO _____	<input type="radio"/> 30 Day Supply <input type="radio"/> 90 Day Supply	

Injection Training

Patient received injection training Prescriber's office to provide injection training Meijer to coordinate injection training Patient to receive injection training at Meijer

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____	Date _____	Physician Signature: _____	Date _____
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Substitution Permitted

Dispense as Written