

Prescriber Information

Prescriber Name:		MD	DO	NP	PA	NPI:
Office Contact:		Practice Name / Collaborating MD:				
Address:		City:		State:		Zip:
Phone:	Fax:					

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patients Name:		Last 4 Digits of SS#:	DOB: / /	Sex: M F	Weight:	Height:	Diabetic? Y N
Address:		City:		State:		Zip:	
Home Phone:		Work/Cell:	HIPAA Contact:		Emergency #:		
Interpreter Needed? Y N	Allergies: Y N If Yes, list allergies:						

Insurance Information

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

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:	Huntington's Disease (G10)	Tardive Dyskinesia (G24)	Other:	Has patient been previously treated for this condition? Y N
Prior failed medication (medication and duration of treatment/reason for d/c):				
Patient currently on therapy? Y N	Medication(s):			
Will patient be stopping above medication before starting new therapy? Y N	Discontinuation Date: / /	Is prescriber a Neurologist? If no, please include neurology consult if available Y N		
Number of relapses in past year:	Last MRI Date: / /	Any MRI Changes? Y N	Is patient pregnant, nursing or planning pregnancy? Y N	
Serum Creatinine:		Creatinine Clearance:		

Prescription Information

Medication	Quantity/Dose	Sig	Quantity	Refills
AUSTEDO®	6mg 9mg 12mg	<u>Dose Titration:</u> Week 1: Week 5: Week 2: Week 6: Week 3: Week 7: Week 4: Week 8:	QS for titration period	No Refills
	6mg 9mg 12mg	<u>Maintenance Dose:</u> Take ____ mg by mouth twice daily	30 Day Supply 90 Day Supply	
AUSTEDO® XR	6mg 12mg 24mg	<u>Dose Titration:</u> Week 1: Week 2: Week 3: Week 4:	QS for titration period	No Refills
	Titration Kit (4 weeks)	<u>Dose Titration:</u> Take as directed on titration package	1 package	No Refills
	6mg 12mg 24mg	<u>Maintenance Dose:</u> Take ____ mg by mouth once daily	30 Day Supply 90 Day Supply	
TETRABENAZINE®	12.5mg 25mg	<u>Dose Titration:</u> Week 1: Week 3: Week 2: Week 4:	QS for titration period	No Refills
	12.5mg 25mg	<u>Maintenance Dose:</u> Take ____ mg by mouth ____ times daily	30 Day Supply 90 Day Supply	

Injection Training

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

Prescriber Signature	Date	Prescriber Signature	Date
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Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.