meijer specialty pharmacy

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**New/Changed Dose**

# Neurology - Huntington's Disease/Tardive Dyskinesia

Austedo™, Tetrabenazine®

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

## Injection Training

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

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 |
|---|---|---|---|
| Substitution Permitted | | Dispense as Written | |

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

**MSP-HuntsDisease-Central-020624**