

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
Office Contact:				Practice Name / Collaborating MD:						
Address:			City:			State:		Zip:		
Home Phone:		Work/Cell:		HIPPA 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) 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					
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™ (Titration Dose)	6mg 9mg 12mg	Dose Titration: Week 1: Week 2: Week 3: Week 4: Week 5: Week 6: Week 7: Week 8:					No Refills			
AUSTEDO™ (Titration Dose)	6mg 9mg 12mg	Maintenance Dose: _____ mg PO _____				30 Day Supply 90 Day Supply				
TETRABENAZINE® (Titration Dose)	12.5mg 25mg	Dose Titration: Week 1: Week 2: Week 3: Week 4:					No Refills			
TETRABENAZINE® (Maintenance Dose)	12.5mg 25mg	Maintenance Dose: _____ mg PO _____				30 Day Supply 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.