meijer specialty pharmacy

P: 1-855-263-4537 • F: 1-866-922-3220
www.meijerspecialtypharmacy.com

New/Changed Dose

Mental Health

Austedo®, Austedo® XR, Spravato®, 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

Patient's 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:	Depression (F____.____)	Tardive Dyskinesia (G24)	Other:

Has patient been previously treated for this condition? Y N **(Provide Information Below)**

Prior Failed Medication:	Reason for Discontinuation of Medication:	Approx. Start Date: / /
		Approx. End Date: / /

Patient currently on therapy? Y N	Medication(s):	Is patient pregnant, nursing or planning pregnancy? Y N
Spravato® Only:	Medication admin appointment date(s):	DEA #:

Prescription Information

Medication	Quantity/Dose	Sig	Quantity	Refills
AUSTEDO®	6mg 9mg 12mg	**Dose Titration:** Week 1: Week 2: Week 3: Week 4: Week 5: Week 6: Week 7: Week 8:	QS for titration period	**No Refills**
	6mg 9mg 12mg	**Maintenance Dose:** Take ___mg by mouth twice daily	30 day supply 90 day supply	
AUSTEDO® XR	6mg 12mg 24mg	**Dose Titration:** Week 1: Week 2: Week 3: Week 4:	QS for titration period	**No Refills**
	Titration Kit (4 weeks)	**Dose Titration:** Take as directed on titration package	1 package	**No Refills**
	6mg 12mg 24mg	**Maintenance Dose:** Take ___mg by mouth twice daily	30 day supply 90 day supply	
SPRAVATO®	56mg 84mg	Administer ___mg nasally twice per week Administer ___mg nasally once weekly Administer ___mg nasally every 2 weeks	28 day supply	
TETRABENAZINE	12.5mg 25mg	**Dose Titration:** Week 1: Week 2: Week 3: Week 4:	QS for titration period	**No Refills**
	12.5mg 25mg	**Maintenance Dose:** Take ___mg by mouth ___times daily	30 day supply 90 day supply	

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.