meijer specialty pharmacy

P: 800-657-2212 • F: 888-592-7723
www.meijerspecialtypharmacy.com

Huntington's Disease

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
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® (Maintenace 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.