CSI Pharmacy
Toll Free: 1-844-680-2944
Pharmacy Fax: 903-223-6109

- Copay Assistance Team
- 24/7 On call Pharmacist
- Prior Authorizations
- Close Clinical Monitoring

Tetrabenazine Order Form

PATIENT INFORMATION

Patient Name		Patient/Caregiver (if applicable)	
Address		City	State Zip code
Main Phone	Alternate phone	Email Address	Last Four of Social (to pull ins. card)
Date of Birth			

DIAGNOSIS: HD - G10 TD - G24.01 Tourettes - F95.2 Dystonia - G24.8 Other

Please include Facesheet, H&P and Clinicals if available (required for PA).

INSURANCE INFORMATION

Insurance Name	Insurance ID number	
BIN number	PCN number	RX Group number

MEDICATION ORDERS

TETRABENAZINE Tablets

Titration/Initiation* Directions

__12.5mg Week 1 _____ 30 Day Supply _____

Week 2 _____

__25mg Week 3 _____ 90 Day Supply _____

Week 4 _____ Refills _____

*If treatment is interrupted for >5 days, re-titration is recommended. If <5 days, resume at previous maintenance dose.

Maintenance

__12.5mg Sig. _____ 30 Day Supply _____

__ 25mg 90 Day Supply _____

_____

Refills _____

PHYSICIAN INFORMATION

Physician Name	Address	City	State	Zip Code
Phone	Fax	NPI	Practice Site Name	
Office Contact and special instructions:				

By signing this form and utilizing our services, you are authorizing CSI PHARMACY and it's employees to serve as your prior authorization agent when dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Date