



**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

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