



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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