CSI Pharmacy
Toll Free: 1-833-569-1005
Pharmacy Fax: 430-200-4889

- 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

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addresses you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.