CSI PHARMACY
Clinical Specialty Infusion, LLC.

CSI Pharmacy
Toll Free: 1-844-680-2944
Pharmacy Fax: 430-200-4889

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

Austedo Order Form

PATIENT INFORMATION

Patient Name		Patient/Caregiver (if applicable)	
Address		City	State Zip code
Main Phone	Alternate phone	Email Address	Last 4 Digits SSN (required)
Date of Birth			

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

Please include Facesheet, H&P and Clinicals.

INSURANCE INFORMATION

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

MEDICATION ORDERS

Austedo (deutetrabenazine) Tablets

	Dosing Schedule	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
TD PATIENT	Total daily dosage	12 mg	18 mg	24 mg	30 mg	36 mg	42 mg	48 mg	
	Sig	6 mg BID	9 mg BID	12 mg BID	15 mg BID	18 mg BID	21 mg BID	24 mg BID	
	Strength/Quantity	6 mg tab (Qty 14)	9 mg tab (Qty 14)	12 mg tab (Qty 14)	6 mg tab + 9 mg tab (Qty 14) (Qty 14)	9 mg tab (Qty 28)	9 mg tab + 12 mg tab (Qty 14) (Qty 14)	12 mg tab (Qty 28)	
HD PATIENT	Total daily dosage	6 mg	12 mg	18 mg	24 mg	30 mg	36 mg	42 mg	48 mg
	Sig	6 mg once daily	6 mg BID	9 mg BID	12 mg BID	15 mg BID	18 mg BID	21 mg BID	24 mg BID
	Strength/Quantity	6 mg tab (Qty 7)	6 mg tab (Qty 14)	9 mg tab (Qty 14)	12 mg tab (Qty 14)	6 mg tab + 9 mg tab (Qty 14) (Qty 14)	9 mg tab (Qty 28)	9 mg tab + 12 mg tab (Qty 14) (Qty 14)	12 mg tab (Qty 28)

TITRATION RX: TD _____ - week titration or HD _____ - week titration

Titrate using dosing schedule above starting with "Week 1" and increasing for the prescribed number of weeks.

MAINTENANCE RX: _____ mg TWICE daily Refills: _____

Quantity: _____ 30 day ____ 90 day

Dispense Qty: use combination of 6mg, 9mg, 12mg tablets to provide appropriate dosing as requested

CSI Pharmacy will

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