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 Enrollment 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.

*This is not a valid prescription