



**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				
<i>Please include Facesheet, H&amp;P and Clinicals if available (required for PA).</i>				

## 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 its employees to serve as your prior authorization agent when dealing with medical and prescription insurance companies.

\*This is not a valid prescription in the state of Alabama.\*