



Austedo® Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-_____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ Group#: _____

Diagnosis

G10 Huntington's disease (HD) G24.01 Tardive Dyskinesia (TD) Other: _____

Clinical Information

Please attach clinical notes, therapy history, AIMS testing and medication list to expedite the prior authorization.

Has patient had prior treatment for this diagnosis? Yes No

Date(s) of previous therapy and medication: _____

Reason(s) for discontinuation: _____

Is prescriber willing to complete peer to peer review if authorization is denied? Yes No

TD Patient

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

TD Titration Rx

_____ - week titration Titrate patient using titration dosing schedule above.

TD Maintenance

_____ mg twice daily Refills: _____
 Quantity sufficient for 30 days

HD Patient

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

HD Titration Rx

_____ - week titration Titrate patient using titration dosing schedule above.

HD Maintenance

_____ mg twice daily Refills: _____
 Quantity sufficient for 30 days

Switch

Current tetrabenazine total daily dosage	12.5mg	25mg	37.5mg	50mg	62.5mg	75mg	87.5mg	100mg
Initial regimen of AUSTEDO®	6mg once daily	6mg BID	9mg BID	12mg BID	15mg BID	18mg BID	21mg BID	24mg BID

Switch Titration Rx

Switch titration dosing instructions:

Switch Maintenance

_____ mg twice daily Refills: _____
 Quantity sufficient for 30 days

Is patient new to this therapy? YES NO | Ship to: Patient Office Other | Need by Date: _____

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____ Preferred Method: Phone Fax Email
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Email: _____

My signature below authorizes Restore Rx Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____

Date: _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: 901-388-0407 | phone: 877-388-0507 | www.restorerx.com