



Tetrabenazine Patient Demographics Form

816 N. 6th Ave.
 Phoenix, AZ 85003
 Phone: (844) 482-2005
 Fax: (833) 437-2301

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name: _____		Prescriber Name: _____	
Address: _____		State License: _____ NPI #: _____	
City, State, Zip: _____		DEA: _____	
Phone: _____ Alt. Phone: _____		Phone: _____ Fax: _____	
DOB: _____ Last 4 SSN: _____		Address: _____	
Gender: M F Height: _____ Weight: _____		City, State, Zip: _____	
Allergies: _____		Office Contact: _____	
INSURANCE INFORMATION - May also scan front and back of insurance card and attach to form			
Primary Insurance: _____		Rx Card (PBM): _____	
Member ID #: _____		BIN: _____ PCN: _____	
Plan # _____		Group #: _____	
Group #: _____		Phone: _____	
Phone: _____		Subscriber Name/DOB: _____	
DIAGNOSIS / CLINICAL INFORMATION - Please attach recent clinical notes and labs with this form			
<input type="checkbox"/> G10 HD <input type="checkbox"/> G24.9 Dystonia CYP2D6 Genotype Testing Results, if known: <input type="checkbox"/> G24.01 TD <input type="checkbox"/> Other Code:			
PRESCRIPTION - Please attached copy of SIGNED PRESCRIPTION with this form			
Please include the following information on prescription: <ul style="list-style-type: none"> • Tetrabenazine strength • Directions for titration/maintenance dosing • Quantity to dispense and refills, if applicable 			
ADMINISTRATION			
Delivery			
Patient Needs Dose by:		Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Other:	

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form and copy of prescription to: (833) 437-2301

Thank you for choosing AvasaRX