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

☐ G10 HD ☐ G24.9 Dystonia CYP2D6 Genotype Testing Results, if known:

☐ G24.01 TD ☐ Other Code:

PRESCRIPTION - Please attached copy of SIGNED PRESCRIPTION with this form

Please include the following information on prescription:

- Tetrabenazine strength
- Directions for titration/maintenance dosing
- Quantity to dispense and refills, if applicable

ADMINISTRATION

Delivery	
Patient Needs Dose by:	Ship to: ☐ Patient ☐ Office ☐ Other:

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

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