



WWW.Biotekrx.com

Tetrabenazine Order Form

Phone: (877) 246-9104

Fax: (888) 963-8122

BioTek reMEDys® has made it convenient for you and your patients who require treatment with Tetrabenazine

PATIENT INFORMATION	PATIENT INFORMATION
Patient Name: _____ DOB: _____	Name: _____ Specialty: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: _____	Phone: _____ Fax: _____
Alt Phone: _____	DEA: _____ NPI: _____

*** PLEASE SEND PATIENT'S FACE SHEET AND CLINICAL TO FACILITATE AUTHORIZATION ***

CLINICAL INFORMATION	PRESCRIPTION INFORMATION
CYP2D6 Genotype Testing Results if known: _____ _____	Date: _____
Diagnosis: _____ _____	Please Check: <input type="checkbox"/> Tetrabenazine 12.5 mg Tablets <input type="checkbox"/> Tetrabenazine 25 mg Tablets
<input type="checkbox"/> HD G10	Week 1 _____
<input type="checkbox"/> TD G24.1	Week 2 _____
<input type="checkbox"/> Dystonia G24.9	Week 3 _____
<input type="checkbox"/> Other _____	Week 4 _____
	Quantity: 30 Days _____ 90 Days _____ Refills _____
	Maintenance: <input type="checkbox"/> Tetrabenazine 25 mg Tablets
	Directions: Sig: _____
	Quantity: 30 Days _____ 90 Days _____ Refills _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain matter 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 to (888)963-8122. Thank you for using BioTek reMEDys