# Tetrabenazine Order

Tele: (346) 708-5160
Fax: (888) 963-8103

www.biotekrx.com

| PATIENT INFORMATION | | | PHYSICIAN INFORMATION | |
|---|---|---|---|---|
| Patient Name: | | | Prescriber Name: | |
| Address: | | | State License: | NPI# |
| City, State, Zip: | | | DEA: | Phone: |
| Phone: | 2nd Phone: | | Address: | Fax: |
| DOB: | | | City, State, Zip: | |
| Weight: | Ht: | Date: | Contact Person: | |
| ICD-10 code: | Diagnosis: | | | |
| Allergies: | | | | |

PLEASE SEND PATIENT'S FACE SHEET AND CLINICALS TO FACILITATE AUTHORIZATION

## CLINICAL INFORMATION

CYP2D6 Genotype testing results if known: ____________
______________________________________________
______________________________________________

Diagnosis: ____________________________________
____________________________________

☐ Huntington's Disease G10
☐ Tardive Dyskinesia G24.1
☐ Dystonia G24.9
☐ Other ______________________________________
______________________________________
______________________________________

## PRESCRIPTION INFORMATION

Date: __________________

Please Check: ☐ Tetrabenazine 12.5 mg tablets
☐ Tetrabenazine 25 mg tablets

Week 1 ________________________________________
Week 2 ________________________________________
Week 3 ________________________________________
Week 4 ________________________________________

Quantity: ☐ 30 Days Refills: __________
☐ 90 Days Refills: __________

Maintenance: ☐ Tetrabenazine 25 mg tablets ☐ Tetrabenazine 12.5 mg tablets

Directions: Sig: ___________________________________

Quantity: ☐ 30 Days Refills: __________
☐ 90 Days Refills: __________

## SIGNATURE

| x ________________________________ (Dispense as Written) Date: | x ________________________________ (Product Substitution Permitted) Date: |
|---|---|

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