



Tetrabenazine Order

Phone: (877)-246-9104

Fax: (800) 783-9146

www.biotekrx.com

PATIENT INFORMATION				PHYSICIAN INFORMATION			
Patient Name:				Prescriber Name:			
Address:				State License:		NPI#	
City, State, Zip:				DEA:		Phone:	
Phone:		2 nd 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	PRESCRIPTION INFORMATION
<p>CYP2D6 Genotype testing results if known: _____</p> <p>_____</p> <p>_____</p> <p>Diagnosis: _____</p> <p>_____</p> <p><input type="checkbox"/> Huntington's Disease G10</p> <p><input type="checkbox"/> Tardive Dyskinesia G24.1</p> <p><input type="checkbox"/> Dystonia G24.9</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p> <p>_____</p>	<p>Date: _____</p> <p>Please Check: <input type="checkbox"/> Tetrabenazine 12.5 mg tablets</p> <p style="padding-left: 40px;"><input type="checkbox"/> Tetrabenazine 25 mg tablets</p> <p>Week 1 _____</p> <p>Week 2 _____</p> <p>Week 3 _____</p> <p>Week 4 _____</p> <p>Quantity: <input type="checkbox"/> 30 Days Refills: _____</p> <p style="padding-left: 40px;"><input type="checkbox"/> 90 Days Refills: _____</p> <p>Maintenance: <input type="checkbox"/> Tetrabenazine 25 mg tablets <input type="checkbox"/> Tetrabenazine 12.5 mg tablets</p> <p>Directions: Sig: _____</p> <p>Quantity: <input type="checkbox"/> 30 Days Refills: _____</p> <p style="padding-left: 40px;"><input type="checkbox"/> 90 Days Refills: _____</p>

SIGNATURE

<p>X _____</p> <p style="text-align: center;">(Dispense as Written)</p> <p>Date: _____</p>	<p>X _____</p> <p style="text-align: center;">(Product Substitution Permitted)</p> <p>Date: _____</p>
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