Phone: (877)-246-9104
Fax: (800) 783-9146
www.biotekrx.com

Tetrabenazine Order

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	**PRESCRIPTION INFORMATION**
CYP2D6 Genotype testing results if known: _____ _____ _____ Diagnosis: _____ _____ ☐ Huntington's Disease G10 ☐ Tardive Dyskinesia G24.1 ☐ Dystonia G24.9 ☐ Other _____ _____ _____	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:

Fax completed form to: (800)783-9146 - Thank you for using BioTek reMEDys®