



Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

New Patient

Date _____

Patient Name _____ DOB _____ Weight _____ Male Female
Street Address: _____ Apt # _____ City _____ State _____ Zip _____
Phone # _____ Cell # _____ Allergies _____

ICD 10 Code: _____

PHYSICIAN INFORMATION

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite # _____ City _____ State _____ Zip _____
Telephone _____ License # _____ NPI # _____ DPS # _____ DEA # _____

CLINICAL INFORMATION

Diagnosis: HD G10 TD G24.01 Dystonia G24.9 _____

CYP2D6 Genotype Testing Results if known: _____

*IMPORTANT: Please sent patients face sheet & clinicals to facilitate authorization.

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Tetrabenazine 12.5mg tablets Tetrabenazine 25mg tablets

Week 1: _____

Week 2: _____

Week 3: _____

Week 4: _____

Quantity: 30 days _____ 90 days _____ Refills: _____

Maintenance: Tetrabenazine 25mg tablets

Directions: Sig: _____

Quantity: 30 days _____ 90 days _____ Refills: _____

ALL controlled substance quantities must be hand written in number and letter form

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

IMPORTANCE NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable laws. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Medicare and Medicaid or another state funded program will not cover above mentioned products. Co-payments due at dispensing of the medication

FDA BLACK BOX WARNING: [NSAID] may cause an increased risk of serious cardiovascular thrombotic event, myocardial-infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk.

Please fax completed form to 1 (888) 294-9434