

# AUSTEDO – TARDIVE DYSKINESIA REFERRAL FORM



Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
 Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 ICD-10 Diagnosis Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Allergies (please note reaction): \_\_\_\_\_  Latex  
 Current Medications: (list here or attach a medication list): \_\_\_\_\_  
 Comorbidities: (list here or attach a list): \_\_\_\_\_

## INSURANCE INFORMATION – FAX COPY OF PATIENT’S INSURANCE CARD – BOTH SIDES

### I. TITRATION DOSE

TARDIVE DYSKINESIA, not currently taking tetrabenazine – Tritate Austedo dose to week \_\_\_\_ based on the following schedule:

Prescription Information

DOSING SCHEDULE	TOTAL DAILY DOSAGE	DIRECTIONS	QUANTITY	REFILLS
Week 1	12mg	6mg BID with food.	6mg tab (qty 14)	
Week 2	18mg	9mg BID with food.	9mg tab (qty 14)	
Week 3	24mg	12mg BID with food.	12mg tab (qty 14)	
Week 4	30mg	15mg (one 6mg tab and one 9mg tab) BID with food.	6mg tab (qty 14) + 9mg (qty 14)	0
Week 5	36mg	18mg (two 9mg tabs) BID with food.	9mg (qty 28)	
Week 6	42mg	21mg (one 9mg tab and one 12mg tab) BID with food.	19mg tab (qty 14) + 12mg tab (qty 14)	
Week 7	48mg	24mg (two 12mg tabs) BID with food.	12mg tab (qty 28)	

Prescription information continued on next page

Other Austedo titration dosing instructions:

*\*Note: Doses should be titrated at weekly intervals by 6mg per day based on the patient's tolerability and symptom control. Maximum recommended total daily dose is 48mg (24mg BID) or 36 (18mg BID) in poor CYP2D6 metabolizers or when used with strong CYP2D6 inhibitors.*

If patient is switching from tetrabenazine

<b>CURRENT TETRABENAZINE TOTAL DAILY USE</b>	12.5mg	25mg	37.5mg	50mg	62.5mg	75mg	87.5mg	100mg
<b>INITIAL AUSTEDO REGIMEN</b>	6mg once daily with food	6mg BID with food	9mg BID with food	12mg BID with food	15mg BID with food	18mg BID with food	21mg BID with food	24mg BID with food

Medication: Austedo

Instructions:

Quantity: Use combination of 6mg, 9mg and 12mg tablets to provide appropriate dosing per titration schedule.

Refills:

**2. MAINTENANCE DOSE**

Medication: Austedo

Total Daily Dose: \_\_\_\_\_mg      Instructions: Take \_\_\_\_\_mg by mouth twice daily with food.

Day Supply:  30 days     90 days

Quantity: Use combination of 6mg, 9mg and 12mg tablets to provide appropriate dosing per titration schedule.

Refills: 0

**Treatment History:**     **New to Therapy**       **Continuation of Therapy**

Prescriber Name: \_\_\_\_\_

State License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Additional Contact Person Name: \_\_\_\_\_

Group or Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_

Product Substitution Permitted

Dispensed as Written

Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Ship to Patient     Ship to Prescriber/Clinic     Pick up at Albertsons Companies Pharmacy    Date Medication Needed: \_\_\_\_\_

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# AUSTEDO – HUNTINGTON’S DISEASE REFERRAL FORM



Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
 Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 ICD-10 Diagnosis Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Allergies (please note reaction): \_\_\_\_\_  Latex  
 Current Medications: (list here or attach a medication list): \_\_\_\_\_  
 Comorbidities: (list here or attach a list): \_\_\_\_\_

## INSURANCE INFORMATION – FAX COPY OF PATIENT’S INSURANCE CARD – BOTH SIDES

### 1. TITRATION DOSE

HUNTINGTON'S DISEASE, not currently taking tetrabenazine – Tritate Austedo dose to week \_\_\_\_ based on the following schedule:

Prescription Information

DOSING SCHEDULE	TOTAL DAILY DOSAGE	DIRECTIONS	QUANTITY	REFILLS
Week 1	12mg	6mg BID with food.	6mg tab (qty 14)	0
Week 2	18mg	9mg BID with food.	9mg tab (qty 14)	
Week 3	24mg	12mg BID with food.	12mg tab (qty 14)	
Week 4	30mg	15mg (one 6mg tab and one 9mg tab) BID with food.	6mg tab (qty 14) + 9mg (qty 14)	
Week 5	36mg	18mg (two 9mg tabs) BID with food.	9mg (qty 28)	
Week 6	42mg	21mg (one 9mg tab and one 12mg tab) BID with food.	19mg tab (qty 14) + 12mg tab (qty 14)	
Week 7	48mg	24mg (two 12mg tabs) BID with food.	12mg tab (qty 28)	

Prescription information continued on next page

Other Austedo titration dosing instructions:

*\*Note: Doses should be titrated at weekly intervals by 6mg per day based on the patient's tolerability and symptom control. Maximum recommended total daily dose is 48mg (24mg BID) or 36 (18mg BID) in poor CYP2D6 metabolizers or when used with strong CYP2D6 inhibitors.*

If patient is switching from tetrabenazine

<b>CURRENT TETRABENAZINE TOTAL DAILY USE</b>	12.5mg	25mg	37.5mg	50mg	62.5mg	75mg	87.5mg	100mg
<b>INITIAL AUSTEDO REGIMEN</b>	6mg once daily with food	6mg BID with food	9mg BID with food	12mg BID with food	15mg BID with food	18mg BID with food	21mg BID with food	24mg BID with food

Medication: Austedo

Instructions:

Quantity: Use combination of 6mg, 9mg and 12mg tablets to provide appropriate dosing per titration schedule.

Refills:

**2. MAINTENANCE DOSE**

Medication: Austedo

Total Daily Dose: \_\_\_\_\_mg      Instructions: Take \_\_\_\_\_mg by mouth twice daily with food.

Day Supply:  30 days     90 days

Quantity: Use combination of 6mg, 9mg and 12mg tablets to provide appropriate dosing per titration schedule.

Refills: 0

**Treatment History:**  **New to Therapy**       **Continuation of Therapy**

Prescriber Name: \_\_\_\_\_

State License #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Additional Contact Person Name: \_\_\_\_\_

Group or Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_

Product Substitution Permitted

Dispensed as Written

Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Ship to Patient     Ship to Prescriber/Clinic     Pick up at Albertsons Companies Pharmacy    Date Medication Needed: \_\_\_\_\_

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