AcariaHealth
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

TETRABENAZINE REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: ❑G10 Huntington's Disease associated with Chorea

- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- If patient is on MAO-I, has patient discontinued for at least 14 days? ❑Yes ❑No

CYP2D6 Metabolizer:

- Extensive/intermediate metabolizer of CYP2D6? ❑Yes ❑No
- Poor metabolizer of CYP2D6? ❑Yes ❑No (max. prescribed dose of 100 mg/day or 37.5 mg/dose)

Current Medical History:

- ❑Depression ❑Current Pregnancy ❑Hepatic Impairment ❑Other: _____

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

❑**Tetrabenazine (Xenazine®) 12.5 mg tablets (OR)** ❑**Tetrabenazine (Xenazine®) 25 mg tablets**

❑Initiation/Titration Dose:

Week 1: _____ QTY: _____ Refills: _____
Week 2: _____ QTY: _____ Refills: _____
Week 3: _____ QTY: _____ Refills: _____
Week 4: _____ QTY: _____ Refills: _____

❑Maintenance Dose 25 mg tablets: _____ QTY: _____ Refills: _____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

3.19.19