AUSTEDO®
(deutetrabenazine) **tablets**

PRESCRIPTION AND SERVICE REQUEST FORM

Please fax completed form to **1-844-257-6126** • For questions, call **1-800-887-8100**

Patient Authorization

I authorize each of my health care provider(s) and my health insurer(s) to use and disclose my protected health information ('PHI') related to: my medical condition and treatment, my health insurance and payment/benefits information, the services provided, and my demographic and contact information to Patient Services and Solutions, Inc. [(d/b/a "Shared Solutions", "Shared Solutions Pharmacy™") and AUSTEDO® dispensing pharmacies (collectively referred to as the "Program")] and its affiliates, agents and representatives, including, but not limited to any third party financial assistance administrators, for the purposes described below.

I understand that the purpose of this Authorization is (i) to enroll me in the Program and contact me by mail, email, or by live, autodialed and/or prerecorded messages and/or other electronic means at the telephone number(s) listed on this form, or to any future telephone number(s) provided by me (ii) to provide therapy support (iii) to conduct benefits investigation and coordinate my insurance coverage (iv) to coordinate prescription fulfillment and financial assistance; (v) for marketing purposes which includes, but is not limited to, providing me with educational and promotional materials, information, special offers and services related to my therapy or my medical condition which may be funded or sent by a Program affiliate; (vi) for market research purposes which includes contacting me to participate in focus groups, surveys or interviews and (vii) to authorize the use and disclosure of my PHI should I choose to participate in the Patient/Caregiver – HD Advocate Support Program.

While the Program will safeguard my information and only use it for intended purposes, I understand that once my health information is disclosed it may be re-disclosed by the Program and other recipients and no longer be protected by federal privacy law. This authorization will remain in effect until the Program ends. I understand that I may revoke this authorization at any time, in writing sent to Patient Services and Solutions, Inc., Attn: Privacy Officer, P.O. Box 7588, Overland Park, KS 66207, but that this revocation will only apply to my health care provider(s) and health insurer(s) once they receive notification of my revocation and only to the extent that they have not already taken action based on it. I understand that my refusal to sign this authorization does not impact my right to treatment, payment for treatment, insurance enrollment, eligibility for insurance benefits, as these are not conditioned on me signing this authorization.

STEP 1: Patient Authorization

Patient Name: (please print)

Patient's Signature: Date:

If signed by someone other than the patient, complete Step 2.

STEP 2: Personal Representative Representation (if applicable)

Note: A Patient's Personal Representative may sign this Form on behalf of the Patient. However, only certain individuals may qualify as the Patient's Personal Representative. State law prescribes who can be a Personal Representative for purposes of this Authorization. Please attach supporting documentation, e.g., Power of Attorney or Guardianship documents.

By signing below, I represent that I am an authorized Personal Representative of the Patient under applicable state law.

Representative Name: Legal Authority:

Signature: Date:

STEP 3: Patient Information/History (please print)

☐ VA ☐ Long Term Care ☐ CMHC Facility Name_____ Phone _____

Name (First, MI, Last, Suffix): DOB: (MM/DD/YEAR) / /

Allergies:

Previous HD/TD Medications: ☐ Xenazine (tetrabenazine) ☐ Other _____

Concurrent Medications:

STEP 4: Insurance Information (attach a copy of patient's insurance card and pharmacy benefits card, front & back)

Medicare D ☐ No Insurance ☐

Pharmacy Insurance Name:			Medical Insurance Name:	
Phone:	Pharmacy ID #:		Phone:	Group #:
BIN #:	PCN #:	Group #:	Policy Holder Name and DOB:	

STEP 5: Clinical Nurse Educator (HD Service Only)

☐ **(Available for HD Patients Only) Check to have a Clinical Nurse Educator coordinate and provide in-home patient medication and adherence education.**

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STEP 6: Patient Information (please print)

Name (First, MI, Last, Suffix):		Date of Birth:	Gender: ☐ Male ☐ Female
Address:	City:	State:	ZIP:
Preferred Name/Contact Number: ☐ Mobile		Alternate Number: ☐ Mobile	
☐ Check here if you consent to receive recurring autodialed promotional text messages from Patient Services and Solutions, Inc. No purchase required. Msg & data rates may apply. Terms and Conditions apply, available at www.pssmobileterms.com.		Email:	

STEP 7: Diagnosis Code

ICD-10 code: ☐ G10 Huntington's disease (HD) ☐ G24.01 Tardive Dyskinesia (TD) ☐ Other ICD-10: _____

STEP 8: AUSTEDO® (deutetrabenazine) tablets Prescription Information (select all that apply)

	Dosing Schedule	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
TD PATIENT	Total daily dosage	12 mg	18 mg	24 mg	30 mg	36 mg	42 mg	48 mg	
	Sig	6 mg BID	9 mg BID	12 mg BID	15 mg BID	18 mg BID	21 mg BID	24 mg BID	
	Strength/Quantity	6 mg tab (Qty 14)	9 mg tab (Qty 14)	12 mg tab (Qty 14)	6 mg tab + 9 mg tab (Qty 14) (Qty 14)	9 mg tab (Qty 28)	9 mg tab + 12 mg tab (Qty 14) (Qty 14)	12 mg tab (Qty 28)	
HD PATIENT	Total daily dosage	6 mg	12 mg	18 mg	24 mg	30 mg	36 mg	42 mg	48 mg
	Sig	6 mg once daily	6 mg BID	9 mg BID	12 mg BID	15 mg BID	18 mg BID	21 mg BID	24 mg BID
	Strength/Quantity	6 mg tab (Qty 7)	6 mg tab (Qty 14)	9 mg tab (Qty 14)	12 mg tab (Qty 14)	6 mg tab + 9 mg tab (Qty 14) (Qty 14)	9 mg tab (Qty 28)	9 mg tab + 12 mg tab (Qty 14) (Qty 14)	12 mg tab (Qty 28)

SWITCH	Current tetrabenazine total daily dosage	12.5 mg	25 mg	37.5 mg	50 mg	62.5 mg	75 mg	87.5 mg	100 mg
	Initial regimen of AUSTEDO®	6 mg once daily	6 mg BID	9 mg BID	12 mg BID	15 mg BID	18 mg BID	21 mg BID	24 mg BID

New Patients (not currently taking tetrabenazine)

See patient dosing schedules above for recommended starting dose (Week 1) and titration. Patients should be titrated up at weekly intervals by 6 mg per day based on reduction of chorea or tardive dyskinesia and tolerability. Use BID dosing for daily dosages ≥ 12 mg. The maximum recommended total daily dosage is 48 mg (max. single dose of 24 mg); or 36 mg (max. single dose of 18 mg) in poor CYP2D6 metabolizers or when used with strong CYP2D6 inhibitors. For patients at risk for QT prolongation, assess QT interval before and after increasing total daily dosage above 24 mg.

TITRATION Rx: TD ☐ _____-week titration OR HD ☐ _____-week titration

Titrate patient using titration dosing schedule above. **REFILLS:** 0

Other titration dosing instructions:

Dispense Qty: Use combination of 6 mg, 9 mg, 12 mg tabs as needed for the titration period

Free Trial Rx* (New Patients):

☐ Check the box to dispense a Free Trial of the prescribed titration above or maintenance dose below. **Voucher and valid prescription required to participate in Free Trial. Download voucher and Terms and Conditions at www.austedocardform.com.**

Dispense Qty: As needed for Rxs (up to 4 weeks for titration OR up to 30 day supply for maintenance)

Maintenance Rx: _____ **mg TWICE daily** **REFILLS:** _____

Day Supply: ☐ 30 day ☐ 90 day

Dispense Qty: Use combination of 6 mg, 9 mg, 12 mg tablets to provide appropriate dosing as requested

Patients Switching from tetrabenazine

See switch patient dosing table above for initial regimen of AUSTEDO®. The dose may be adjusted at weekly intervals of 6 mg per day (see new patient schedule). Use BID dosing for daily dosages ≥ 12 mg. The maximum recommended total daily dosage is 48 mg (max. single dose of 24 mg); or 36 mg (max. single dose of 18 mg) in poor CYP2D6 metabolizers or when used with strong CYP2D6 inhibitors. For patients at risk for QT prolongation, assess QT interval before and after increasing total daily dosage above 24 mg.

Switch titration dosing instructions:

Dispense Qty: Use combination of 6 mg, 9 mg, 12 mg tabs as needed for the titration period

Maintenance Rx: _____ **mg TWICE daily** **REFILLS:** _____

Day Supply: ☐ 30 day ☐ 90 day

Dispense Qty: Use combination of 6 mg, 9 mg, 12 mg tablets to provide appropriate dosing as requested

Free Trial Rx* (Switch Patients):

☐ Check the box to dispense an up to 30-day Free Trial of the prescribed AUSTEDO® titration/maintenance dose above. **Voucher and valid prescription required to participate in Free Trial. Download voucher and Terms and Conditions at www.austedocardform.com.**

Dispense Qty: As needed for the titration/maintenance dose only (up to 30 days)

*Free Trial Rx available one time for patients within labeled indication only for up to 4 weeks of titration or 30 days of maintenance. Not contingent on purchase of any kind. Free Trial Rx may not be submitted for reimbursement to any third party payer.

Bridge Rx†:

☐ Check the box for Shared Solutions Pharmacy™ (1-866-930-4146) to dispense a free bridge fill for the prescribed AUSTEDO® maintenance dose above.

†Bridge Rx is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge Rx is intended to support continuation of prescribed therapy if there is a delay in insurance coverage determination. Bridge Rx may not be submitted for reimbursement to any third party payers. We reserve the right to modify or terminate the program without notice at any time.

STEP 9: Prescriber Information

Prescriber Name:	Check if: ☐ MD ☐ NP ☐ PA ☐ DO	NPI #:	
Office Address:	City:	State:	Zip:
Nurse/Office Contact:	Phone:	Fax:	

Prescriber Signature (required for prescription orders)

After discussing the AUSTEDO® Program (including its agents, service providers and AUSTEDO® dispensing pharmacies) with the patient, the patient has elected to participate in the Program. I authorize the release of medical and/or other patient information relating to AUSTEDO® therapy to this Program, Patient Services & Solutions, Inc., and its designated agents and service providers, including but not limited to AUSTEDO® dispensing pharmacies, to use and disclose as needed for fulfillment of the prescription related to this Program, and furnish any information in this form to the insurer of the above-named patient. I also authorize the forwarding of this prescription and related information by the Program, acting as my authorized agent, to an AUSTEDO® dispensing pharmacy.

STAMP SIGNATURE NOT PERMITTED – INK SIGNATURE ONLY. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws
The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form or hard copy prescription, etc.

X_____ X_____

Dispense as written (Date) Brand exchange permissible (Date)