Austedo® XR Referral Form

(deutetrabenazine) extended-release tablets

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

First Name		Last Name		Date of Birth			
Address		City		State		ZIP	
Last Four Digits of the SSN		US Resident:	☐ Yes ☐ No	Gender:	☐ Male ☐ Female		
Preferred Phone		Is Preferred Phone a mobile number?	☐ Yes ☐ No	Email			
Alternate Contact/Care Partner		Alternative Contact/Care Partner					
Patient/Authorized Representative Signature				Date			
Description of Authorized Representative's Authority:							
(Optional) I consent to have my prescription shipped to:	☐ Care Partner	☐ LTC	☐ HCP Office	☐ Group Home			
Patient Residence Category	☐ At Home	☐ LTC	☐ Group Home	☐ Other			

Patient Insurance Information

Medical Insurance Name				Prescription Insurance Name			
Card Holder ID #				Card Holder ID #			
Policy Holder Name:				Bin#:		PCN	
Phone:		Policy Holder DOB		Rx Group #:		Phone	
Payer Type	☐ Commerical	☐ Medicare	☐ Medicaid	☐ Other	☐ Patient Does Not Have Insurance		

Prescription for Austedo XR

ICD-10 CODE ☐ G24.01 Tardive Dyskinesia (TD) ☐ G10 H ICD-10 CODE untington's Chorea (HD) ☐ Other ICD-10 _____

☐ 4-WEEK TITRATION KIT

NDC: 68546-490-52
12 mg once-daily x Week 1
18 mg (12 mg + 6 mg) once-daily x Week 2
24 mg once-daily x Week 3
30 mg (24 mg + 6 mg) once-daily x Week 4

Apply 30-day free trial voucher

☐ CONTINUING & SAMPLED PATIENTS

Titrate weekly by 6 mg/day from current dose _____ mg/day to reach the dose selected below (select one):

☐ 24 mg/day ☐ 42 mg/day
☐ 30 mg/day ☐ 48 mg/day
☐ 36 mg/day – Dose selection following initial 4–week titration

Refills # _____

☐ Other Rx or Switch from Tetrabenazine* Sig: _____ Quantity: _____ Refills: _____

Apply 30-day free trial voucher for INITIAL Rx only

***Start at 50% of current TBZ dose.**

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Prescriber Insurance Information

After discussing the Program for AUSTEDO XR (including its agents, service providers, and dispensing pharmacies of AUSTEDO XR) 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 therapy to this Program, Patient Services and Solutions, Inc., its affiliates and its designated agents and service providers, including but not limited to dispensing pharmacies of AUSTEDO XR, 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 a dispensing pharmacy of AUSTEDO XR.
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.

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

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 electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Date

Prescriber's Signature

X _____