AUSTEDO®
(deutetrabenazine) **tablets**

PRESCRIPTION AND SERVICE REQUEST FORM

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

STEP 1: Patient Information/History (please print)

☐ VA ☐ Long Term Care ☐ CMHC Facility Name: Phone:

Name (First, MI, Last, Suffix): | Date of Birth: | Gender: ☐ Male ☐ Female

Address: | City: | State: | ZIP:

Preferred Name/Contact Number: ☐ Mobile | Alternate Number: ☐ Mobile

Email:

Allergies:

Previous TD Medications:

Concurrent Medications:

STEP 2: 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 3: Diagnosis Code

ICD-10 code: ☐ G24.01 Tardive Dyskinesia (TD) ☐ Other ICD-10: _____

STEP 4: AUSTEDO® Prescription Information (select all that apply)

TD Dosing Schedule	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7
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)

Recommended starting dose (12 mg per day, given as 6 mg BID) should be titrated up at weekly intervals by 6 mg per day based on reduction of 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. See dosing schedule above. For patients at risk for QT prolongation, assess QT interval before and after increasing total daily dosage above 24 mg.

Free Trial Rx*

☐ Check the box to dispense a Free Trial of the prescribed titration/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 Rx (up to 4 weeks for Titration OR up to 30 day supply for Maintenance)

*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.

Titration Rx: ☐ _____-week titration **REFILLS:** 0 **Other titration dosing instructions:**
Titrate patient using titration dosing schedule above.

Maintenance Rx: Dispense Qty: Use combination of 6 mg, 9 mg, 12 mg tabs as needed for Rx.
_____ **mg TWICE daily** **Day Supply:** ☐ 30 day ☐ 90 day **REFILLS:** _____

STEP 5: 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, Teva Pharmaceuticals USA, Inc., its affiliates 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_____ Dispense as written (Date)

X_____ Brand exchange permissible (Date)

Patient Authorization

I authorize my healthcare providers, pharmacies and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions and health insurance to Teva Pharmaceuticals USA, Inc. and its affiliates, contractors and agents, including its third party patient support program service provider (collectively "Teva") for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support, including product administration training and education; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research and Program related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders, and support, for which the third party service provider may receive financial remuneration from the manufacturer of your medication.

I understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorizations, P.O. Box 7588, Overland Park, KS 66207, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

☐ By checking this box, I certify that I am at least 18 years old and consent to receive promotional or educational messages from Teva and its affiliates and agents by direct mail and email, as well as electronic or telephonic means at the telephone number provided on this form using automated technology and/or prerecorded voice messages, to provide me with information regarding movement disorders, Teva products, and programs and to conduct market research. I understand my consent is not a condition of purchase. Additional terms apply: http://www.pssmobileterms.com/.

STEP 6: Patient Authorization

Patient Name: (please print)

Patient Signature: Date:

If signed by someone other than the patient, describe legal authority to do so: