# Austedo® and Austedo® XR Enrollment Form

VALUE SPECIALTY PHARMACY

## Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name/Phone: _____

Sex: ❑ Male ❑ Female Height: _____ Weight: _____ lbs kg
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Patient Email: _____

## Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ Group#: _____

❑ ***Patient has commercial insurance and authorizes pharmacy to apply for manufacturer copay card. Email must be provided above.***

## Diagnosis

❑ G10 Huntington's disease (HD) ❑ G24.01 Tardive Dyskinesia (TD) ❑ Other: _____

## Clinical Information

***Please attach clinical notes, therapy history, AIMS testing and medication list to expedite the prior authorization***

Has patient had prior treatment for this diagnosis? ❑ Yes ❑ No

Date(s) of previous therapy and medication: _____

_____

Reason(s) for discontinuation : _____

_____

Is prescriber willing to complete peer-to-peer review if authorization is denied? ❑ Yes ❑ No

## Austedo®

| Dosing Schedule | Week 1 | Week 2 | Week 3 | Week 4 | Week 5 | Week 6 | Week 7 | Week 8 |
|---|---|---|---|---|---|---|---|---|
| Total Daily Dosage | 12mg | 18mg | 24mg | 30mg | 36mg | 42mg | 48mg | |
| Sig | 6mg BID | 9mg BID | 12mg BID | 15mg BID | 18mg BID | 21mg BID | 24mg BID | |
| Strength/Quantity | 6mg tab (Qty 14) | 9mg tab (Qty 14) | 12mg tab (Qty 14) | 6mg tab + 9mg tab (Qty 14) (Qty 14) | 9mg tab (Qty 28) | 9mg tab + 12mg tab (Qty 14) (Qty 14) | 12mg tab (Qty 28) | |

## Prescription

| Medication | Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ❑ Austedo® Titration Rx | _____ - week titration | Titrate patient using tritration dosing schedule above | Quantity sufficent for 30 days | 0 Refills |
| ❑ Austedo® | ❑ 6mg tablet<br>❑ 9mg tablet<br>❑ 12mg tablet | Take _____mg orally twice daily | Quantity sufficent for 30 days | |
| ❑ Austedo® XR | ❑ Titration Starter Pack | Induction: Use as directed per titration pack instructions | #1 pack | 0 Refills |
| | ❑ 6mg tablet<br>❑ 12mg tablet<br>❑ 18mg tablet<br>❑ 24mg tablet<br>❑ 30mg tablet<br>❑ 36mg tablet<br>❑ 42mg tablet<br>❑ 48mg tablet | Take 1 tablet orally once daily | #30 | |

**Is patient new to this therapy:** ❑ YES ❑ NO | **Ship to:** ❑ Patient ❑ Office ❑ Other | **Need by Date:** _____

## Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____
Phone: _____ Fax: _____
Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right.