Patient Information

PRESCRIPTION AND SERVICE REQUEST FORM

AUSTEDO® (deutetrabenazine) **tablets**

shared solutions® support. knowledge. answers.

Please fax **COMPLETED** form to **1-844-257-6126** · For questions, call **1-800-887-8100** · 8 am–8 pm CT M–F

PATIENT INFORMATION

Name (First, MI, Last, Suffix):

DOB (MM/DD/YYYY): Gender: ☐ Male ☐ Female ☐ Unspecified

Address: City: State: ZIP:

Home Phone: Mobile: Email Address:

INSURANCE

A copy of patient's INSURANCE CARD + PHARMACY BENEFITS CARD (front and back) must accompany form when faxed.

NEEDED FOR PROCESSING

☐ Medicare D ☐ No Insurance Pharmacy Insurance Name: Medical Insurance Name:

Phone: Pharmacy ID#: Phone: Group #:

BIN #: PCN #: Group #: Policy Holder Name and DOB:

PATIENT HISTORY

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

Facility Phone:

Allergies:

Previous Medications:

☐ Xenazine® (tetrabenazine)

☐ Other: _____

Concurrent Medications:

PATIENT AUTHORIZATION AND SIGNATURE

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 7613, Overland Park, KS 66207-9941, 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.

ENROLL IN SHARED SOLUTIONS®

☐ By checking this box, I certify that I am at least 18 years old and consent to receive informational 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.

SMS Text Opt-In Consent: Would you like to receive autodialed informational text messages from the Shared Solutions support program?

☐ Yes ☐ No No purchase required. Message and data rates may apply. Message frequency varies. Reply STOP to opt out, HELP for help.

SMS terms and Privacy Policy: http://www.pssmobileterms.com.

NEEDED FOR PROCESSING

Patient or Personal Representative Signature: Date:

If signed by someone other than the patient, complete the following information:

Name: Legal authority to sign on patient behalf:

Prescriber Information

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PRESCRIBER INFORMATION

NEEDED FOR PROCESSING

Prescriber Name: Check if: ☐ MD ☐ NP ☐ PA ☐ DO NPI #:

Office Address: City: State: ZIP:

Nurse/Office Contact: Phone: Fax:

Do you have a preferred pharmacy? You can add it here:

ICD-10 Code

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

DOSING AND TITRATION

Select checkbox below for initial or continuing treatment for TD or HD chorea, filling in any blank fields.

TD

☐ INITIAL 30-DAY Rx

INITIAL Rx:
12 mg/day (6 mg BID) x 7 days
Titrate weekly by 6 mg/day x 23 days
Apply 30-day free trial voucher

CONTINUING AFTER FIRST 30 DAYS Rx:
_____ mg/day | 1-month supply
Refills # _____

OR

☐ SAMPLED PATIENTS 30-DAY Rx FOLLOWING SAMPLES

INITIAL Rx:
24 mg/day (12 mg BID) x 7 days
30 mg/day (15 mg* BID) x 23 days
Apply 30-day free trial voucher

CONTINUING AFTER FIRST 30 DAYS Rx:
_____ mg/day | 1-month supply
Refills # _____

OR

☐ MAINTENANCE

_____ mg/day x 30 days
Additional information: _____
Refills # _____

HD

☐ INITIAL 30-DAY Rx

INITIAL Rx:
6 mg/day x 7 days
Titrate weekly by 6 mg/day x 23 days
Apply 30-day free trial voucher

CONTINUING AFTER FIRST 30 DAYS Rx:
_____ mg/day | 1-month supply
Refills # _____

OR

☐ SAMPLED PATIENTS 30-DAY Rx FOLLOWING SAMPLES

INITIAL Rx:
18 mg/day (9 mg BID) x 7 days
24 mg/day (12 mg* BID) x 23 days
Apply 30-day free trial voucher

CONTINUING AFTER FIRST 30 DAYS Rx:
_____ mg/day | 1-month supply
Refills # _____

OR

☐ MAINTENANCE

_____ mg/day x 30 days
Additional information: _____
Refills # _____

☐ PATIENTS SWITCHING FROM TETRABENAZINE

INITIAL RX: _____ mg/day x _____ days **(Approx. 50% of current TBZ dose)**
Titrate weekly by 6 mg/day x _____ days

MAINTENANCE RX: _____ mg/day x 30 days
Apply 30-day free trial voucher

*Dispense Qty: Use combination of 6 mg, 9 mg, and 12 mg tablets as needed for Rx. Use BID dosing for daily dosages ≥ 12 mg.
In patients who are poor CYP2D6 metabolizers or are taking strong CYP2D6 inhibitors, the total daily dosage of AUSTEDO should not exceed 36 mg (maximum single dose of 18 mg).
Free Trial Voucher available for patients starting on AUSTEDO. Certain restrictions apply. Terms and conditions on www.Austedocardform.com.

PRESCRIBER SIGNATURE

After discussing the Program for AUSTEDO (including its agents, service providers and dispensing pharmacies of AUSTEDO) 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, Teva Pharmaceuticals USA, Inc., its affiliates and its designated agents and service providers, including but not limited to dispensing pharmacies of AUSTEDO, 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.

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.

NEEDED FOR PROCESSING

Dispense as written Date: Brand exchange permissible Date:

Fax completed form plus a front/back copy of the patient's insurance card and pharmacy benefit card to Shared Solutions®

teva