meijer specialty pharmacy

P: 1-855-263-4537 • F: 734-391-2365
www.meijerspecialtypharmacy.com

Huntington's Disease

Physician Information

Send updates to: ◯ Fax: _____ ◯ Email: _____ ◯ Text: _____

Prescriber Name:		◯ MD ◯ DO ◯ NP ◯ PA	NPI:
Office Contact:	Practice Name / Supervising MD:		
Address:	City:		
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	◯ Huntington's Disease (G10) ◯ Other:		Has patient been previously treated for this condition? ◯ Y ◯ N	
Prior failed medication (medication and duration of treatment/reason for d/c): ◯				
Patient currently on therapy? ◯ Y ◯ N Medication(s):		Will patient be stopping above medication before starting new therapy? ◯ Y ◯ N		Discontinuation Date: / /
Is prescriber a Neurologist? If no, please include neurology consult if available	◯ Other:	Number of relapses in past year:	Last MRI date: / /	Any MRI changes? ◯ Y ◯ N
Is patient pregnant, nursing or planning pregnancy? ◯ Y ◯ N ◯ N/A	◯ Serum Creatinine:	◯ Creatinine Clearance:		

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
◯ **AUSTEDO**™ (Titration Dose)	◯ 6mg ◯ 9mg ◯ 12mg	◯ **Dose Titration:** Week 1: _____ Week 2: _____ Week 3: _____ Week 4: _____ Week 5: _____ Week 6: _____ Week 7: _____ Week 8: _____		**NO REFILLS**
◯ **AUSTEDO**™ (Maintenance Dose)	◯ 6mg ◯ 9mg ◯ 12mg	◯ **Maintenance Dose:** _____ mg PO _____	◯ 30 Day Supply ◯ 90 Day Supply	
◯ **TETRABENAZINE**® (Titration Dose)	◯ 12.5mg ◯ 25mg	◯ **Dose Titration:** Week 1: _____ Week 2: _____ Week 3: _____ Week 4: _____		**NO REFILLS**
◯ **TETRABENAZINE**® (Maintenance Dose)	◯ 12.5mg ◯ 25mg	◯ **Maintenance Dose:** _____ mg PO _____	◯ 30 Day Supply ◯ 90 Day Supply	

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature:	Date	Physician Signature:	Date

Substitution Permitted

Dispense as Written