Zarina Pharmacy
SPECIALTY & INFUSION

Austedo

Fax: 800-269-5493 Phone: 888-292-0744 zarinapharmacy.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

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

Complete This Section for Tardive Dyskinesia (TD):
Abnormal Involuntary Movement Score (AIMS): Date: _____ Score: _____ Date: _____ Score: _____

History: Has the patient been previously treated for this condition? ☐ No ☐ Yes, Medication Failed: _____
Is the patient currently on therapy? ☐ No ☐ Yes, Medication Failed: _____

Drug Allergies

Status:
☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Austedo XR® Starter Kit	4 Week Patient Titration Kit	Week 1: 12 mg by mouth once daily Week 2: 18 mg (12 mg + 6 mg) by mouth once daily Week 3: 24 mg by mouth once daily Week 4: 30 mg (24 mg + 6 mg) by mouth once daily	1 kit (42 tablets)	None
☐ Austedo XR®	☐ 6 mg Tablet ☐ 12 mg Tablet ☐ 24 mg Tablet (Select all strengths required per directions)	☐ **Continuing Titration and Sampled Patients** Titrate weekly by 6 mg/day from current dose ____mg/day to reach the dose selected below (select one) ☐ 24 mg/day (24 mg [2 x 12 mg] by mouth once daily) ☐ 30 mg/day (30 mg [24 mg + 6 mg] by mouth once daily) ☐ 36 mg/day (36 mg [3 x 12 mg] by mouth once daily) ☐ 42 mg/day (42 mg [3 x 12 mg + 6 mg] by mouth once daily) ☐ 48 mg/day (48 mg [2 x 24 mg] by mouth once daily)	QS For Titration	None
		☐ **Maintenance Rx** ☐ 24 mg/day (24 mg [2 x 12 mg] by mouth once daily) ☐ 30 mg/day (30 mg [24 mg + 6 mg] by mouth once daily) ☐ 36 mg/day (36 mg [3 x 12 mg] by mouth once daily) ☐ 42 mg/day (42 mg [3 x 12 mg + 6 mg] by mouth once daily) ☐ 48 mg/day (48 mg [2 x 24 mg] by mouth once daily)	30 Day Supply	_____
		☐ **Other Rx** _____ _____ _____	_____	_____

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) **Substitution Permitted** **Date**

Prescriber's Signature (no stamps) **Dispense As Written** **Date**

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Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

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

Complete This Section for Tardive Dyskinesia (TD):
Abnormal Involuntary Movement Score (AIMS): Date: _____ Score: _____ Date: _____ Score: _____

History: Has the patient been previously treated for this condition? ☐ No ☐ Yes, Medication Failed: _____
Is the patient currently on therapy? ☐ No ☐ Yes, Medication Failed: _____

Drug Allergies	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Austedo®	☐ 6 mg Tablet ☐ 9 mg Tablet ☐ 12 mg Tablet (Select all strengths required per directions)	☐ **Initial Titration Rx - Tardive Dyskinesia** To reach 30 mg/day Maintenance Dose Week 1: 12 mg/day (6 mg by mouth twice a day) Week 2: 18 mg/day (9 mg by mouth twice a day) Week 3: 24 mg/day (12 mg by mouth twice a day) Week 4: 30 mg/day (15 mg [6 mg + 9 mg] by mouth twice a day)	QS For Titration	None
		☐ **Initial Titration Rx - Huntington's Chorea** To reach 24 mg/day Maintenance Dose Week 1: 6 mg/day (6 mg by mouth once a day) Week 2: 12 mg/day (6 mg by mouth twice a day) Week 3: 18 mg/day (9 mg by mouth twice a day) Week 4: 24 mg/day (12 mg by mouth twice a day)	QS For Titration	None
		☐ **Continuing Titration and Sampled Patients** Titrate weekly by 6mg/day from current dose ____mg/day to reach the dose selected below (select one) ☐ 24 mg/day (12 mg by mouth twice daily) ☐ 30 mg/day (15 mg [6 mg + 9 mg] by mouth twice a day) ☐ 36 mg/day (18 mg [2 x 9 mg] by mouth twice daily) ☐ 42 mg/day (21 mg [9 mg + 12 mg] by mouth twice daily) ☐ 48 mg/day (24 mg [2 x 12 mg] by mouth twice daily)	QS For Titration	None
		☐ **Maintenance Rx** ☐ 24 mg/day (12 mg by mouth twice daily) ☐ 30 mg/day (15 mg [6 mg + 9 mg] by mouth twice a day) ☐ 36 mg/day (18 mg [2 x 9 mg] by mouth twice daily) ☐ 42 mg/day (21 mg [9 mg + 12 mg] by mouth twice daily) ☐ 48 mg/day (24 mg [2 x 12 mg] by mouth twice daily)	30 Day Supply	_____
		☐ **Other Rx** _____ _____ _____	_____	_____

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