TETRABENAZINE ORDERS

FOR QUESTIONS, CALL 1.800.323.6832 | Fax all pages to (855) 270-7347

Patient Information

Order Date:	Requested Start of Care Date:		Date of Birth:
Patient name:	Height:	Weight: lb / kg	
Address:	City:	State:	Zip:

CYP2D6 genotype testing metabolizer:
◯ unknown ◯ poor ◯ intermediate ◯ extensive

Primary Diagnosis: ☐ Huntington's disease G10 ☐ Tardive dyskinesia G24. 01 ☐ Tourette syndrome F95.2
☐ Hemiballism G25.5 (other chorea) ☐ Hyperkinetic dystonia G24. 9 (dystonia, unspecified)
☐ Other ICD-10:

Secondary Diagnosis / ICD-10:

Allergies:

Tetrabenazine Order

Rx #1 Tetrabenazine 12.5 mg tablet ☐ decline
Rx #2 Tetrabenazine 25 mg tablet ☐ decline
Pharmacy to dispense either/both strengths to best follow orders unless decline box checked.

Qty: up to 30-day supply or ____ day supply
Refill up to 1 yr or ___ month(s)

◯ Option #1 - Order as below:

Week	Total Daily Dose	Stop at this dose for maintenance OR until intolerable side effects	Regimen (n/a = not applicable) AM	afternoon	PM
1	12.5 mg	◯	12.5 mg	n/a	n/a
2	25 mg	◯	12.5 mg	n/a	12.5 mg
3	37.5 mg	◯	12.5 mg	12.5 mg	12.5 mg
4	50 mg	◯	12.5 mg	12.5 mg	25 mg
5	62.5 mg	◯	12.5 mg	25 mg	25 mg
6	75 mg	◯	25 mg	25 mg	25 mg
7	87.5 mg	◯	25 mg	25 mg	37.5 mg
8	100 mg	◯	25 mg	37.5 mg	37.5 mg

◯ Option #2 - Order as below:

Week	Total Daily Dose (mg)	Regimen
1		
2		
3		
4		
5		
6		
7		
8		

◯ Option #3 - Continue regimen: Tetrabenazine _____ mg in AM _____ mg in afternoon _____ mg in PM

◯ Option #4 - Other regimen:

Physician Information

Signature:	Name:
	NPI#:
	Address:
Date:	Phone: Fax:

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