Note: This prescription is valid only if transmitted by facsimile from the prescriber's office. This form is not a valid prescription in Arizona or Virginia. Physician must attest that this is his/her legal signature (no stamps). Prescriber must comply with his/her state-specific requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable laws in your state.

AUSTEDO/AUSTEDO XR Prescription & Enrollment Form

Genoa Healthcare®

PATIENT INFORMATION

Last Name: _____ First Name: _____

Address: _____

City: _____ State/Zip: _____

Phone: _____ DOB: _____

Insurance Company: _____

ID #: _____ Group #: _____

PRESCRIPTION INFORMATION

Diagnosis (ICD10): _____

☐ **G24.01** Tardive Dyskinesia ☐ **G10** Huntington's Chorea ☐ Other: _____

Allergies: _____

PRESCRIPTION FOR AUSTEDO/AUSTEDO XR – Check box for initial and/or current treatment, filling in blank fields

☐ **Austedo XR 4-Week**
Titration Kit

NDC: 68546-0477-29
12mg once-daily x Week 1
18mg once-daily x Week 2
24mg once-daily x Week 3
30mg once daily x Week 4

☐ **Austedo XR Continuing & Sampled Patients**
Titrate weekly by 6mg/day from current dose of ___mg/day to reach the dose selected below (select one):

☐ 24mg/day – NDC: 68546-0472-56
☐ 30mg/day – NDC: 68546-0473-56
☐ 36mg/day – NDC: 68546-0474-56
☐ 42mg/day – NDC: 68546-0475-56
☐ 48mg/day – NDC 68546-0476-56
Quantity: _____
Refills #: _____

AUSTEDO PRESCRIPTION (twice daily formulation)

☐ Austedo 6mg: Sig:_____ Quantity: _____ Refills #: _____

☐ Austedo 9mg: Sig:_____ Quantity: _____ Refills #: _____

☐ Austedo 12mg: Sig:_____ Quantity: _____ Refills #: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____

Office Address: _____

Phone: _____ Fax: _____

SIGNATURE

Prescriber Signature: _____ Date: _____