PRESCRIPTION AND SERVICE REQUEST FORM

AUSTEDO® (deutetrabenazine) **tablets** | teva | Shared Solutions

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:

ENROLL IN teva | Shared Solutions

By signing here, I authorize the use and disclosure of my Protected Health Information as set forth in the HIPAA Authorization **on page 2**.

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:

☐ By checking this box, I authorize Teva Neuroscience, Inc. ("Teva"), its affiliates, and the companies working with Teva to contact me by direct mail, email, telephone (including autodialed and/or prerecorded calls and/or messages), and electronic messages for marketing and promotional purposes, to conduct market research or surveys, and to use my information to develop future products, services, and programs.

I understand that I may choose to no longer receive further communications from Teva by following the unsubscribe instructions on the communication. Opting in to these communications is not a requirement or a condition of purchase. Terms and conditions apply: www.pssmobileterms.com

☐ By checking this box, I am enrolling in the Teva **Shared Solutions® Adherence Program only**, and will not be submitting medication, coverage, or prescription details with this form. **NOTE: DO NOT FILL OUT REMAINDER OF FORM IF THIS BOX IS CHECKED.**

INSURANCE

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

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

Phone: Pharmacy ID#: Phone: Group #:

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

ICD-10 CODE

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

NEEDED FOR PROCESSING

PRESCRIPTION FOR AUSTEDO

Check box below for initial and/or current treatment, filling in any blank fields.

☐ INITIAL TITRATION Rx

To reach 30 mg/day dose:

- 12 mg/day (6 mg BID) x Week 1
- 18 mg/day (9 mg BID) x Week 2
- 24 mg/day (12 mg BID) x Week 3
- 30 mg/day (15 mg BID) x Week 4

No Refills

Apply 30-day free trial voucher

☐ CONTINUING & SAMPLED PATIENTS

Titrate weekly by 6 mg/day from current dose _____ mg/day to reach the dose selected below **(select one)**:

☐ 36 mg/day (18 mg BID) – Dose selection following initial 4–week titration

☐ 42 mg/day (21 mg BID)

☐ 48 mg/day (24 mg BID)

Refills #: _____

☐ Other Rx or Switch from Tetrabenazine* Sig: Quantity: Refills #:

Apply 30-day free trial voucher for INITIAL Rx only

*Start at 50% of current TBZ dose.

PREFERRED PHARMACY

Name of Preferred Pharmacy*:

Phone: Fax:

Address: City: State:

*Prescription will be triaged to preferred pharmacy unless otherwise dictated by insurance mandate and/or patient preference.

Dispense Qty: Use combination of 6 mg, 9 mg, and 12 mg tablets as needed for Rx above 30 mg/day.
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.

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PATIENT INFORMATION

Patient Name: _____ DOB (MM/DD/YYYY): _____

FACILITY INFORMATION

Facility Name: _____

Facility Phone: _____

☐ VA
☐ Long-Term Care
☐ CMHC

PRESCRIBER INFORMATION

NEEDED FOR PROCESSING

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

Office Address: _____ City: _____ State: _____ ZIP: _____

Nurse/Office Contact: _____ Phone: _____ Fax: _____

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, Patient Services and Solutions, 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

Prescriber Signature: _____ Date: _____

☐ Dispense as Written ☐ Brand Exchange Permissible

PATIENT AUTHORIZATION

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 Patient Services and Solutions, 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 5490, Louisville, KY 40255, 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.

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

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