Xenazine® (tetrabenazine) Treatment Form

Xenazine® (tetrabenazine) 12.5 and 25 mg Tablets

Step 1: Patient Information

Name: _____
(First) (Middle) (Last)

Sex: ❑ Male ❑ Female DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____

Best Time to Call: _____ E-mail: _____

Preferred Contact Person: _____

Phone: _____ Cell Phone: _____

Ship to: (If different from above) ❑ Skilled Nursing Facility ❑ Hospital ❑ Other _____

Facility Name: (if applicable) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Contact Person: _____

Special Shipping Instructions: _____

Step 2: Patient Insurance—complete the information below OR include copies of insurance cards

Primary Insurance

Name of Medical Plan: _____ Phone: _____

Relationship to Cardholder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Cardholder Name: _____ Plan Number: _____

Group Number: _____ ID Number: _____

Secondary Insurance

Cardholder Name: _____ Plan Number: _____

Group Number: _____ ID Number: _____

Employer: _____ Phone: _____

Prescription Insurance

Name of Prescription Plan: _____ Phone: _____

Rx BIN: _____ Rx PCN: _____

Rx ID #: _____ Group #: _____

Step 3: Patient Authorization for Use and Disclosure of Personal Health Information

I authorize my healthcare providers (including pharmacy providers) and health plans to disclose my personal health information related to this prescription form or my use or potential use of XENAZINE, including my personal contact information on this form (collectively, my "Information"), to the patient support program called the XENAZINE Information Center (the "Program") so that the Program may use and disclose the Information in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my benefit and coverage status and my medical care; (3) provide support services, including facilitating the provision of XENAZINE to me, as well as any information or materials related to such services or Lundbeck products, including promotional or educational communications; (4) evaluate the effectiveness of XENAZINE support programs; (5) report safety information, including in communications with the US Food and Drug Administration and other government authorities; (6) contact me regarding this prescription form or my use or potential use of XENAZINE and provide me with related patient support communications, including through messages left for me that disclose that I take or may take XENAZINE; and (7) allow Lundbeck to analyze the usage patterns and the effectiveness of Lundbeck products, services, and programs and help develop new products, services, and programs, and for other Lundbeck general business and administrative purposes.

I understand that my pharmacy provider(s) may receive remuneration in exchange for the provision of my Information as authorized above, and that once my Information has been disclosed to the Program, federal privacy law may no longer restrict its use or disclosure and that it may be redisclosed to others. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law.

I understand that if I refuse to sign this Authorization, that will not affect my right to treatment or payment of benefits for health care. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to the XENAZINE Information Center at PO Box 8725, Gaithersburg, MD 20898-9801, and that such withdrawal will not affect any uses and disclosures of my Information prior to the Program's receipt of the notice. I am entitled to a copy of this signed Authorization, which expires 10 years from the date it is signed by me or such timeframe as allowed by law.

➔ **Patient/Parent/Legal Guardian Signature:** _____

➔ **Date: Month** _____ **Day** _____ **Year** _____

➔ **Power of Attorney:** ❑ Yes ❑ No ❑ N/A **Power of Attorney (First, Middle, Last):** _____

Please see Indication and Important Safety Information, including Boxed Warning for depression and suicidality, on page 3.
For more information, please see the accompanying Xenazine full Prescribing Information, or go to www.xenazineusa.com.

Questions? 1-888-882-6013 Fax form to 1-866-341-5601

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Step 4: Prescriber Information

Prescriber Name: _____
(First) (Last)

Specialty: ❑ Neurology ❑ Other: _____

Prescriber Address: _____

Prescriber Address #2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ NPI #: _____

Physician Office Contact: _____ Phone: _____

Step 5

℞ **Patient Name:** _____
(First) (Middle) (Last)

Patient Date of Birth: _____
MM/DD/YYYY

Xenazine® (tetrabenazine) Date: _____

❑ 12.5-mg tablets 30 Day Supply Quantity: _____ 90 Day Supply Quantity: _____

❑ 25-mg tablets 30 Day Supply Quantity: _____ 90 Day Supply Quantity: _____

Refills: _____

Titration schedule (per week)

Week 1: _____

Week 2: _____

Week 3: _____

Week 4: _____

ICD-10 Code: ❑ G10 Huntington's disease

Prescriber Signature - STAMP SIGNATURE NOT ALLOWED

➔ Dispense as written* _____ Date: _____

➔ Product Substitution Permitted _____ Date: _____

*Requirements for DAW may vary by state

Contact XIC at 1-888-882-6013 if you need assistance

Step 6: Prescriber Authorization

Prescriber Certification and Authorization: I certify that, to the full extent required by applicable law, I have obtained written permission from my patient named above (or from the patient's legal representative) to release to the patient support program, the Xenazine Information Center ("the Program"), the patient's personal health information, both as provided on this form and such other personal health information as the Program may need (1) to perform a preliminary verification of the patient's insurance coverage for XENAZINE, (2) to assess the patient's eligibility for participation in the Program, (3) to enroll the patient in the Program, (4) to provide reimbursement support and other services to the patient in connection with the patient's prescription(s) on this form, and (5) for the other purposes identified on the Patient Authorization for Use and Disclosure of Personal Health Information. I authorize and appoint the Program to convey on my behalf the prescription(s) I signed for the patient and the other information included on this form to the dispensing pharmacy chosen by or for the patient. I agree that the Program may contact me, including without limitation via email, fax, and telephone, to seek additional information relating to the Program, XENAZINE, or the prescription(s) contained on this form.

I understand that any XENAZINE provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment or reimbursement for such products to any third-party payor, including a federal health care program. If I am or become in possession of such product, I will not resell or attempt to resell the product.

➔ **Prescriber Signature:** _____ Date: _____

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Healthcare Professional: Please share page 4 and the Consumer ISI on page 5 with patient or caregiver

Welcome to Xenazine® (tetrabenazine) Treatment

Your doctor just prescribed Xenazine for you. This sheet describes the next steps as you start your Xenazine treatment

Read the Medication Guide that comes with Xenazine before you start taking it and each time you refill the prescription. There may be new information. This information does not take the place of talking with your doctor about your medical condition or your treatment. You should share this information with your family members and caregivers.

What to expect next

1. Insurance coverage information

- ⇢ After completing this form with your doctor, it will be faxed to the Xenazine Information Center
- ⇢ The Xenazine Information Center will:
  - – Coordinate with your insurance provider to confirm coverage information for Xenazine
  - – Contact you and your healthcare provider to provide you with insurance coverage information for Xenazine

2. Prescription delivery

- ⇢ Once your insurance coverage is verified, a specialty pharmacy will fill your Xenazine prescription based on your doctor's instructions. The exact specialty pharmacy that will send your medication depends on your insurance plan. The pharmacy could be Accredo, Caremark, Curascript, or Advanced Care Scripts (ACS)
  - – A representative from the specialty pharmacy will call you regarding the delivery of your Xenazine
  - – Always return calls from your specialty pharmacy because they cannot send your medication without speaking to you or your designated representative
    - Note, these calls will appear as blocked or unavailable on your caller ID

Your Xenazine initial dosing schedule

You or your doctor can write down your initial dosing schedule here. He or she will give you specific instructions on how much Xenazine you should take and how often.

	Xenazine Dose			
Time of Day	Week 1	Week 2	Week 3	Week 4

Please carefully read the Important Safety Information, including Boxed Warning about the increased risk of depression and suicidality, on the back. Please refer to the accompanying Xenazine full Prescribing Information and Medication Guide for more information.

The Xenazine Information Center is here to help

If you have questions about your insurance coverage and/or how you will be sent the Xenazine prescribed by your doctor, please call the Xenazine Information Center toll-free at 1-888-882-6013 (8:00 AM-6:00 PM ET, Monday through Friday).

For more information, you can also visit www.xenazineusa.com. There you will find the latest Xenazine Medication Guide.

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