## Xenazine\* (tetrabenazine) Treatment Form \*Yenazine is a registered trademark of Cambridge Laboratories (Ireland) Limited

| TO BE COMPLETED BY PATI  | ENT/CAREGIVER   |  |  |   |  |
|--|---|--|--|---|--|
| Name (First, Middle, Last):  |   | Sex:   | ☐ Male ☐ Female  | DOB:/   | /  |
| Address:   |   |  |  | State:  | Zip Code:  |
| Phone:   |   |  | ent or Legal Guardian:   |   |  |
| Currently on tetrabenazine: 🗖 Yes 🗖 No   | Pare  | Parent or Legal Guardian Phone:  |  |   |  |
| Shipping Instructions: (if different from  | ı above)  |  | ŭ  | _   |  |
| Name:  | ,   | Add  | ress:  |   |  |
| City:  |   |  |  |   |  |
| Phone:   |   |  |  |   |  |
| authorize my healthcare provider tetrabenazine to Ovation and its a my benefit eligibility; 2) communical care; 3) provide support service penazine's education programs. I the Xenazine Information Center a understand that once my health                               | gents and contractors ("Over<br>cate with my healthcare pro<br>es, including facilitating the<br>agree that using the contact<br>and may leave messages for<br>information has been discla-   | ation") and I authorize ( viders and health plans provision of tetrabena; of information I provide or me that disclose that                            | Ovation to use and disabout my benefit are in et and 4) to ovation may get in take tetrabenazine.  | sclose this information of coverage street the expension of the expension of the control of the | mation to: 1) establish atus and my medi- ffectiveness of tetra- for reasons related to  |
| Ovation agrees to protect my infor understand I may refuse to sign thi change, but I will not have access notifying Ovation in writing and subdisclosing my information for the poarticipation in the Xenazine Infornsigned by me.  Name of Medical Plan:                  | rmation by using and disclo<br>is authorization and that if I is<br>to the Xenazine supports<br>omitting it by fax to 1-866-34<br>ourposes listed above, excep<br>mation Center. I am entitled  | osing it only for the purporefuse, my eligibility for invives described hereir 41-5601 or by calling 1-pt as required by law of the copy of this signe | oses described above health plan benefits on . I may also cancel the 888-882-6013. If I cancer as necessary for the dauthorization, which  | e or as required<br>and treatment b<br>sel, Ovation will<br>orderly termina<br>n expires 10 year  | d by law. I further by my doctor will not n in the future by cease using or ation of my ars from the date it is                                  |
| Cardholder Name:   | <br>Plan Nur  | nber:  | Group Number:  | ID N  | umber:   |
| Name of Prescription Plan:   |   |  |  |   |  |
| Cardholder Name:   |   |  |  |   |  |
| Employer:  |   |  |  |   | <del></del>  |
| The information provided about patien promptly if such status should change.  Patient / Parent / Legal Guardian  |   |  | of my knowledge. I will u  |   | rine Information Center  |
|  |   |  | Daic   |   |  |
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| TO BE COMPLETED BY OFF   | ICE STAFF   |  |  |   |  |
| Patient Name:  |   | Date:  |  | ICD-9 C   |  |
| Patient Name:<br>Xenazine (tetrabenazine) □12.5mg ta   |   | Date:  |  | □ 33<br>Hu  |  |
| Patient Name:<br>Xenazine (tetrabenazine) □12.5mg ta   | abletsQuantity pletsQuantity  | Date:  |  | □ 33<br>Hu  | 33.4<br>untington's Chorea   |
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