

Xenazine* (tetrabenazine) Treatment Form

*Xenazine is a registered trademark of Cambridge Laboratories (Ireland) Limited

TO BE COMPLETED BY PATIENT/CAREGIVER

Name (First, Middle, Last): _____ Sex: Male Female DOB: ____/____/____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____ Alternative Phone: _____ Parent or Legal Guardian: _____
Currently on tetrabenazine: Yes No Parent or Legal Guardian Phone: _____

Shipping Instructions: (if different from above)

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

I authorize my healthcare providers and health plans to disclose personal and medical information related to my use or potential use of tetrabenazine to Ovation and its agents and contractors ("Ovation") and I authorize Ovation to use and disclose this information 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 tetrabenazine to me; and 4) to evaluate the effectiveness of tetrabenazine's education programs. I agree that using the contact information I provide, Ovation may get in touch with me for reasons related to the Xenazine Information Center and may leave messages for me that disclose that I take tetrabenazine.

I understand that once my health information has been disclosed to Ovation, privacy laws may no longer restrict its use or disclosure; however, Ovation agrees to protect my information by using and disclosing it only for the purposes described above or as required by law. I further understand I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my doctor will not change, but I will not have access to the Xenazine support services described herein. I may also cancel this authorization in the future by notifying Ovation in writing and submitting it by fax to 1-866-341-5601 or by calling 1-888-882-6013. If I cancel, Ovation will cease using or disclosing my information for the purposes listed above, except as required by law or as necessary for the orderly termination of my participation in the Xenazine Information Center. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Name of Medical Plan: _____ Phone Number: _____ Relationship to Cardholder: Self Spouse Child Other
Cardholder Name: _____ Plan Number: _____ Group Number: _____ ID Number: _____
Name of Prescription Plan: _____ Phone Number: _____ Rx BIN: _____ Rx PCN: _____
Cardholder Name: _____ Plan Number: _____ Group Number: _____ ID Number: _____
Employer: _____ Phone Number: _____

The information provided about patients insurance status is complete and accurate to the best of my knowledge. I will update the Xenazine Information Center promptly if such status should change.

Patient / Parent / Legal Guardian Signature: _____ Date: _____

TO BE COMPLETED BY OFFICE STAFF

Patient Name: _____ Date: _____

Xenazine (tetrabenazine) 12.5mg tablets _____ Quantity
 25mg tablets _____ Quantity

Directions for use (including titration directions):

Refills: _____
(Digits and written words)

- Dispense as written
 Substitution allowed

Prescriber Signature: _____ Date: _____
(No Stamped Signature)

Prescriber's Name (First, Middle Initial, Last): _____ NPI #: _____

Prescriber Address: _____ Specialty: Neurology Other: _____

Address 2: _____

City: _____ State: _____ Zip: _____ State License #: _____

Phone: _____ Fax: _____ Physician Office Contact: _____ Phone: _____

I certify that Xenazine therapy is medically necessary and that this information is accurate to the best of my knowledge.

I appoint TheraCom as my agent for the sole purpose of conveying this prescription to the pharmacy chosen by the patient or patient's insurance plan.

I authorize Theracom LLC, acting as the Xenazine Information Center to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information in this form to the insurer of the above-named patient and to obtain any information about the patient, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or health care operation purposes. As my business associate, TheraCom is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

Prescriber Signature: _____ Date: _____ TheraCom Signature: _____ Date: _____
(No Stamped Signature)

Prescriber Fax to 1-866-341-5601

Please complete this form in its entirety.

www.xenazineusa.com