



# Huntington's Disease Intake Form

**E-Prescribing to AllCare Plus Pharmacy Available**

NCPDP 2243880 Toll free (855) 880-1091 Toll free fax (844) 265-0265

50 Bearfoot Road, Northborough, MA 01532

www.AllCarePlusPharmacy.com

DATE: \_\_\_\_\_ THERAPY START DATE: \_\_\_\_\_ DELIVERY :  PATIENT  OFFICE  OTHER: \_\_\_\_\_

PATIENT INFORMATION	
Patient Name	
Address	
City, State, Zip	
Phone	
Social Security	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFORMATION	
Prescriber Name	
DEA/NPI #	
Preparer Name/Office Contact	
Address	
City, State, Zip	
Phone	Fax

**INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK**

## CLINICAL INFORMATION

**Primary Diagnosis & ICD-10 Code:**

G10 Huntington's disease

**Other ICD-10 Code:** \_\_\_\_\_

**Diagnosis Date:** \_\_\_\_\_

Is this patient currently on therapy?  Yes  No

Medication(s): \_\_\_\_\_

Other medications patient is currently taking including OTC medications with dosage and directions (or fax medication profile):  
\_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**Additional Notes:** \_\_\_\_\_

## PRESCRIPTION INFORMATION

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Tetrabenazine	<input type="checkbox"/> 12.5 mg Tablets <input type="checkbox"/> 25 mg Tablets	Directions for use (including titration directions): _____ _____	_____	_____
<input type="checkbox"/> Other	_____	Directions for use (including titration directions): _____ _____	_____	_____

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265