

Healthcare Professional: Tear off and give to patient or caregiver

Welcome to Xenazine Treatment

Your doctor just prescribed Xenazine® (tetrabenazine) 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. Verification of your medical insurance information

- After completing this form with your doctor, it will be faxed to the Xenazine Information Center
- The Xenazine Information Center will then verify your benefits

2. Talking about your co-pay

- The Xenazine Information Center will contact you about your co-pay
- If you need help paying for your medication, ask the Xenazine Information Center about REACH™

3. Prescription delivery*

- The first Xenazine prescription will be delivered by the fifth business day after the Xenazine Information Center receives a completed Xenazine Treatment Form from your doctor

4. Follow-up†

- Check the box on the treatment form if you wish to enroll into the REACH Patient Support Program
- A nurse from the Xenazine Information Center will call to follow up on how you are doing with your treatment for HD chorea with Xenazine

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.

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

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.

For more information, you can also visit www.XenazineUSA.com. There you will find the latest Xenazine Medication Guide and *What You Need to Know About Xenazine: Patient/Caregiver Counseling Guide*.

*Program not available in all states.

†If you and your doctor have opted in to this program.

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

Xenazine®
(tetrabenazine)
12.5 and 25 mg Tablets

Xenazine® (tetrabenazine) Tablets

Indications and Usage:

Xenazine is a medicine that is used to treat the involuntary movements (chorea) of Huntington's disease. Xenazine does not cure the cause of the involuntary movements, and it does not treat other symptoms of Huntington's disease, such as problems with thinking or emotions.

It is not known whether Xenazine is safe and effective in children.

Important Safety Information:

- **Xenazine can increase the chance of depression, suicidal thoughts or suicidal actions in some patients.**
- **You should not start taking Xenazine if you are depressed (have untreated depression or depression that is not well controlled by medicine) or have suicidal thoughts.**
- **Pay close attention to any changes, especially sudden changes, in mood, behaviors, thoughts or feelings. This is especially important when Xenazine is started and when the dose is changed.**

Do not take Xenazine if you have liver problems or are taking monoamine oxidase inhibitors or reserpine. At least 20 days should pass after stopping reserpine before starting Xenazine. Tell your doctor if you are pregnant, breast-feeding or have breast cancer.

The need for therapy should be evaluated on an ongoing basis with your doctor. The dose of Xenazine should be adjusted slowly over several weeks for a dose that is appropriate for you. If your doctor thinks you need to take more than 50 mg of Xenazine each day, you will need to have a blood test to see if Xenazine is safe for you.

Neuroleptic malignant syndrome (NMS), restlessness, agitation, parkinsonism (slight shaking, body stiffness, trouble moving or keeping your balance), trouble swallowing, dizziness, and irregular heartbeat have also been reported with use of Xenazine. Do not use Xenazine with drugs known to cause irregular heartbeat. Side effects associated with Xenazine, such as irregular heartbeat, NMS, and parkinsonism, may be increased if used together with drugs called dopamine antagonists. Uncontrolled movements called tardive dyskinesia (TD) may develop in patients treated with Xenazine. It is possible that the TD will not go away.

Xenazine may cause sleepiness or drowsiness, and may affect the ability to drive or use dangerous machinery. Some side effects, such as depression, tiredness, trouble sleeping, sleepiness/drowsiness, parkinsonism, and restlessness, may be dose-dependent. If the side effects don't stop or lessen, your doctor should consider lowering the dose or stopping your Xenazine. The most commonly reported side effects in studies with Xenazine were sleepiness/drowsiness, tiredness, trouble sleeping, depression, restlessness, anxiety, and nausea.

Please see full Xenazine Medication Guide and full Prescribing Information, including Boxed Warning about depression and suicidality, at www.xenazineusa.com.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Xenazine® is a registered trademark of Biovail Laboratories International (Barbados) S.R.L.



Treatment Form

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

Please complete this form in its entirety and fax to XIC at 1-866-341-5601

Enroll into REACH™ Patient Support Program

Patient Information

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

Sex: Male Female DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alt. Phone: _____

Best Time to Call: _____ E-mail: _____

Parent/Legal Guardian: _____

Phone: _____ Alt. Phone: _____

Ship to: (If different from above)

Address: _____

City: _____ State: _____ Zip Code: _____

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: _____

Patient Authorization

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

I authorize my healthcare providers and health plans to disclose personal and medical information related to my use or potential use of tetrabenazine to Lundbeck Inc. and its agents and contractors ("Lundbeck") and I authorize Lundbeck 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) evaluate the effectiveness of tetrabenazine's education programs. I agree that using the contact information I provide, Lundbeck 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 Lundbeck, privacy laws may no longer restrict its use or disclosure; however, Lundbeck 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 Lundbeck in writing and submitting it by fax to 1-866-341-5601 or by calling 1-888-882-6013. If I cancel, Lundbeck 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.

I authorize Lundbeck to release information provided in this enrollment form to the Xenazine Information Center for the provision of education, training, and ongoing support on the use of Xenazine. I authorize Lundbeck to use and give out my information to send me information or materials related to Xenazine (or any other related products or services in which I might be interested), to contact me by phone by a Registered Nurse to discuss my treatment, to contact me occasionally to get my feedback (for market research purposes) about Xenazine or the Xenazine Information Center to operate (and improve the quality of) the Xenazine Information Center otherwise as required or permitted by law. I understand that if I do not wish to receive information related to Xenazine (or any related products or services) or to be contacted occasionally for market research purposes, that I may call the Xenazine Information Center's number 888-882-6013 at any time.

Patient/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

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: _____

Prescription Information

ICD-9 Code: 333.4 Huntington's Chorea

Directions for use (including titration directions and complete schedule):

Initial Rx	Week 1	Week 2	Week 3	Week 4
Morning				
Afternoon				
Evening				

Xenazine® (tetrabenazine)

12.5-mg tablets Quantity: _____ 25-mg tablets Quantity: _____ Refills: _____

Dispense as written Substitution allowed

Prescriber Signature: _____ Date: _____

(No Stamped Signature)

Prescriber Authorization

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

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 healthcare 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: _____



©2010 Lundbeck Inc. August 2010 XZN182BR1-W All rights reserved.
Xenazine® is a registered trademark of Biovail Laboratories International (Barbados) S.R.L.
www.XenazineUSA.com

Xenazine®
(tetrabenazine)
12.5 and 25 mg Tablets