OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Xenazine® (tetrabenazine) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chorea associated with Huntington's disease
❑ Hyperkinetic movement disorders in tardive dyskinesia and Tourette's syndrome
❑ Other diagnosis: ____________________________________ ICD-10 Code(s): ______________________________

Medication History:

For brand Xenazine requests: Does the patient have history of trial and failure or intolerance to generic tetrabenazine? ❑ **Yes** ❑ **No**

Prescriber's Specialty:

Select if Xenazine/tetrabenazine prescribed by or in consultation by one of the following specialists:
- ❑ Neurologist
- ❑ Psychiatrist

For tardive dyskinesia, answer the following:

Is the patient a candidate for a trial of dose reduction, tapering or discontinuation of the offending medication? ❑ **Yes** ❑ **No**

Does the patient have persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication? ❑ **Yes** ❑ **No**

For Tourette's syndrome, answer the following:

Does the patient have tics associated with Tourette's syndrome? ❑ **Yes** ❑ **No**
Does the patient have history of failure, contraindication, or intolerance to Haldol (haloperidol)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Is there documentation the patient has had a positive clinical response to Xenazine/tetrabenazine therapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Xenazine-tetrabenazine_Comm_2018Aug-W