



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://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 (Page 1 of 2)

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| 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: |
| <input type="checkbox"/> Check if requesting <b>brand</b>  |        |  | Directions for Use:             |        |              |
| <input type="checkbox"/> Check if request is for <b>continuation of therapy</b>  |        |  |                                 |        |              |
| Clinical Information (required)  |        |  |                                 |        |              |
| <b>Select the diagnosis below:</b>   |        |  |                                 |        |              |
| <input type="checkbox"/> Chorea associated with Huntington's disease   |        |  |                                 |        |              |
| <input type="checkbox"/> Tardive dyskinesia  |        |  |                                 |        |              |
| <input type="checkbox"/> Tourette's syndrome   |        |  |                                 |        |              |
| <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____  |        |  |                                 |        |              |
| <b>Clinical Information:</b>   |        |  |                                 |        |              |
| Select if the requested medication is <b>prescribed by</b> one of the following specialists:   |        |  |                                 |        |              |
| <input type="checkbox"/> Neurologist   |        | <input type="checkbox"/> Psychiatrist  |                                 |        |              |
| Select if the requested medication is prescribed <b>in consultation with</b> one of the following specialists:   |        |  |                                 |        |              |
| <input type="checkbox"/> Neurologist   |        | <input type="checkbox"/> Psychiatrist  |                                 |        |              |
| Select if the patient has history of failure, contraindication, or intolerance to the following:   |        |  |                                 |        |              |
| <input type="checkbox"/> Austedo   |        | <input type="checkbox"/> Generic tetrabenazine (for brand Xenazine requests) |                                 |        |              |
| <b>For tardive dyskinesia, also answer the following:</b>  |        |  |                                 |        |              |
| Does the patient have stereotypes associated with tardive dyskinesia? <input type="checkbox"/> Yes <input type="checkbox"/> No   |        |  |                                 |        |              |
| <b>For Tourette's syndrome, also answer the following:</b>   |        |  |                                 |        |              |
| Does the patient have tics associated with Tourette's syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No   |        |  |                                 |        |              |
| Has the patient had trial and failure, contraindication, or intolerance to Haldol (haloperidol)? <input type="checkbox"/> Yes <input type="checkbox"/> No  |        |  |                                 |        |              |
| <b>Reauthorization:</b>  |        |  |                                 |        |              |
| <b>If this is a reauthorization request, answer the following question:</b>  |        |  |                                 |        |              |
| Is there documentation the patient has had a clinical response and benefit from therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No  |        |  |                                 |        |              |
| <b>Quantity Limit:</b>   |        |  |                                 |        |              |
| What is the quantity requested per DAY? _____  |        |  |                                 |        |              |
| <b>What is the reason for exceeding the plan limitations?</b>  |        |  |                                 |        |              |
| <input type="checkbox"/> Titration or loading-dose purposes  |        |  |                                 |        |              |
| <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)   |        |  |                                 |        |              |
| <input type="checkbox"/> Requested strength/dose is not commercially available   |        |  |                                 |        |              |
| <input type="checkbox"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. <b>Please specify:</b> _____ |        |  |                                 |        |              |
| <input type="checkbox"/> Other: _____  |        |  |                                 |        |              |

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\_CMS\_2019Jan-W



## Xenazine<sup>®</sup> (tetrabenazine) Prior Authorization Request Form (Page 2 of 2)

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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.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

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.