PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xenazine (brand tetrabenazine)

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the prescribing physician a neurologist?

☐ Yes ☐ No

Q2. For what diagnosis is this being prescribed (pick one)?

☐ Chorea associated with Huntington's Disease
☐ Tourette's Syndrome
☐ Tic disorder
☐ Tardive dyskinesia
☐ Other

Q3. Please provide the ICD diagnosis code for the above condition.

Q4. If for tardive dyskinesia, does the patient have failure of an adequate trial, intolerance or contraindication to clonazepam?

☐ Yes ☐ No

Q5. If for Tourette's Syndrome or tic disorder, does the patient have failure of an adequate trial, intolerance or contraindication to any of the following? (Please select all that apply)

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

- ☐ Clonidine
- ☐ Guanfacine
- ☐ Haloperidol
- ☐ Pimozide
- ☐ Risperidone
- ☐ Other (please specify)

Q6. Does the patient have failure of an adequate trial of or clinically significant intolerance to generic tetrabenazine?

☐ Yes ☐ No

Q7. Additional Comments:

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.