AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Xenazine and Tetrabenazine

Beneficiary Information

1. Beneficiary Last Name: ________________________________ 2. First Name: ________________________________
3. Beneficiary ID #: ___________________ 4. Beneficiary Date of Birth: _____________ 5. Beneficiary Gender: _________

Prescriber Information

6. Prescriber Name: ______________________________________ NPI #: ________________________
Mailing address: ______________________________________ City: _____________ State: _________ ZIP: _______
7. Requester Contact Information: ____
Name: ______________________________ Phone #: ______________________ Fax #: _______________________

Drug Information

8. Drug Name: _______________________ 9. Strength: _______________ 10. Quantity Per 30 Days: _____________
11. Length of Therapy: Initial Request: ___up to 30 ___60 ___90 ___120 ___180
(# of days) Continuation Request: ___ up to 30 ___60 ___90 ___120 ___180 ___365

Clinical Information

1. Does the beneficiary have a diagnosis of moderate to severe Huntington's Disease and is experiencing signs and symptoms of chorea? Yes__ No__
2. Is the beneficiary age 18 or older? Yes___ No___
3. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? Yes___ No___
4. Is the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? Yes___ No___
5. Does the beneficiary have a history of depression or suicidal ideation? Yes___ No___
6. Is the beneficiary receiving treatment and/or is stable? Yes___ No___
7. If prescribing Tetrabenazine, has the beneficiary tried and failed ONE preferred drug in the same class? Yes___ No___

****For Continuation of Therapy, attach documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.****

Signature of Prescriber: ___________________________ Date: ____________________

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406