pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

XENAZINE/TETRABENAZINE PRIOR AUTHORIZATION FORM

- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Xenazine (tetrabenazine)** and **Quantity Limits/Daily Dose Limits,** accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request PA# _____	# of pages in request: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Xenazine tablet ☐tetrabenazine tablet			
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx codes (*required*):	
Section A: ALL requests			
1. Do any of the following contraindications apply to the Recipient? *Check all that apply*. ☐actively suicidal ☐taken an MAO inhibitor in the past 14 days ☐hepatic impairment ☐taken reserpine in the past 20 days ☐depression that is untreated or inadequately treated		☐Yes ☐No	*Submit supporting documentation, including liver function test (LFT) results, mental health evaluation, and medication list.*
2. *If the Recipient will be taking a strong CYP2D6 inhibitor (such as bupropion, fluoxetine, paroxetine, or quinidine)*, will the dose of tetrabenazine be adjusted accordingly?		☐Yes ☐No	*Submit documentation of tetrabenazine dosing and Recipient's complete medication list.*
3. *If the Recipient's dose of tetrabenazine exceeds 50 mg per day*, is there documentation of therapeutic failure at a dose of ≤ 50 mg/day AND of CYP450 2D6 genotyping that shows intermediate or extensive metabolism?		☐Yes ☐No	*Submit documentation of dose and therapeutic failure AND results of genotype testing.*
Section B: INITIAL requests			
1. Does the Recipient have a diagnosis of chorea associated with Huntington's Disease?	☐Yes – *submit documentation supporting Recipient's diagnosis.* ☐No – *submit medical literature documentation supporting the use of tetrabenazine for the Recipient's diagnosis.*		
2. Is tetrabenazine being prescribed by or in consultation with a neurologist?	☐Yes ☐No	*If prescriber is not a neurologist, submit documentation of consultation with a neurologist.*	
3. Has the prescriber performed a mental health evaluation of the Recipient?		☐Yes ☐No	*Submit documentation of evaluation.*
4. *If the Recipient has a history of prior suicide attempt, bipolar disorder, or major depressive disorder*, has the Recipient been evaluated and treated by a psychiatrist?		☐Yes ☐No	*Submit documentation of evaluation and treatment regimen.*
Section C: RENEWAL requests			
1. Since starting tetrabenazine, has the Recipient experienced an improvement in chorea?		☐Yes ☐No	*Submit documentation of Recipient's response to therapy.*
2. Was the Recipient reevaluated (and treated, if applicable) for new onset or worsening symptoms of depression and determined to be a candidate for treatment with tetrabenazine?		☐Yes ☐No	*Submit documentation of evaluation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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