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 (preferred) / TETRABENAZINE (non-preferred) PRIOR AUTHORIZATION FORM

Prior authorization guidelines and quantity limits are available at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name/phone of office contact:		Specialty:	
LTC facility contact/phone:		NPI:	State license #:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Xenazine tablet* (preferred with clinical PA required) ☐tetrabenazine tablet (non-preferred)

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx codes (*required*):	

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? (***NOTE**: Xenazine is only available from one of the two DHS specialty pharmacies – Walgreen's Specialty.) ☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy

ALL requests	
1. Do any of the following contraindications apply to the beneficiary? *Check all that apply.* ☐actively suicidal ☐taken an MAO inhibitor in the past 14 days ☐hepatic impairment ☐taken reserpine in the past 20 days ☐taking Austedo or Ingrezza ☐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 beneficiary will be taking a strong CYP2D6 inhibitor (such as bupropion, fluoxetine, paroxetine, or quinidine)***, will the dose of Xenazine be adjusted accordingly?	☐Yes ☐No *Submit documentation of dosing and Beneficiary's complete medication list.*
3. ***If the beneficiary's dose of Xenazine exceeds 50 mg per day***, does the beneficiary have 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.*
INITIAL requests	
1. Does the beneficiary have one of the following diagnoses? ☐chorea associated with Huntington's disease ☐tardive dyskinesia	☐Yes – *Submit documentation supporting beneficiary's diagnosis.* ☐No – *Submit medical literature documentation supporting the use of Xenazine for the beneficiary's diagnosis.*
2. Is Xenazine being prescribed by or in consultation with a neurologist or psychiatrist?	☐Yes ☐No *If prescriber is not a neurologist, submit documentation of consultation with a neurologist or psychiatrist.*
3. Did the beneficiary have a mental health evaluation?	☐Yes ☐No *Submit documentation of evaluation.*
4. ***If the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder***, was the Beneficiary evaluated in the past 6 months and treated by a psychiatrist?	☐Yes ☐No *Submit documentation of evaluation and treatment.*
5. ***For the treatment of tardive dyskinesia***, *submit documentation of the following* as it applies to the beneficiary: ☐has no other causes of involuntary movement ☐a dose decrease of dopamine receptor blocking agents is not appropriate ☐has documentation of TD severity ☐other therapies for TD are not appropriate	
6. ***Requests for non-preferred tetrabenazine:*** Does the beneficiary have a history of trial and failure of, or contraindication or intolerance to, the preferred medication, **Xenazine**?	☐Yes ☐No *Submit documentation.*
RENEWAL requests	
1. Since starting Xenazine, did the beneficiary experience an improvement in the medical condition being treated?	☐Yes ☐No *Submit documentation of beneficiary's response to therapy.*
2. Was the beneficiary reevaluated (and treated, if applicable) for new onset or worsening symptoms of depression and determined to be a candidate for treatment with Xenazine?	☐Yes ☐No *Submit documentation of evaluation.*

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

Prescriber Signature:	**Date**: