

### XENAZINE (tetrabenazine) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **VMAT2 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages: _____		Prescriber name:	
Name of office contact:				Specialty:	
Contact's phone number:				NPI:	State license #:
LTC facility contact/phone:				Street address:	
Beneficiary name:				Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:		Fax:

#### **CLINICAL INFORMATION**

<b>Medication requested:</b> <input type="checkbox"/> tetrabenazine tablet ( <i>preferred with clinical PA required</i> )		<input type="checkbox"/> Xenazine tablet ( <i>non-preferred</i> )	
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		Dx codes ( <i>required</i> ):	

#### **ALL requests**

Do any of the following contraindications apply to the beneficiary? <i>Check all that apply.</i>		<input type="checkbox"/> Yes <i>Submit supporting documentation, including liver function test (LFT) results, mental health evaluation, and medication list.</i>	
<input type="checkbox"/> actively suicidal	<input type="checkbox"/> taken an MAO inhibitor in the past 14 days		
<input type="checkbox"/> hepatic impairment	<input type="checkbox"/> taken reserpine in the past 20 days		
<input type="checkbox"/> taking Austedo or Ingrezza	<input type="checkbox"/> depression that is untreated or inadequately treated		
<b><i>If the beneficiary will be taking a strong CYP2D6 inhibitor (such as bupropion, fluoxetine, paroxetine, or quinidine), will the dose of tetrabenazine be adjusted accordingly?</i></b>		<input type="checkbox"/> Yes <i>Submit documentation of dosing and Beneficiary's complete medication list.</i>	
<b><i>If the beneficiary's dose of tetrabenazine 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?</i></b>		<input type="checkbox"/> Yes <i>Submit documentation of dose and therapeutic failure AND results of genotype testing.</i>	

#### **INITIAL requests**

Does the beneficiary have one of the following diagnoses?		<input type="checkbox"/> Yes – <i>Submit documentation supporting beneficiary's diagnosis.</i>	
<input type="checkbox"/> chorea associated with Huntington's disease	<input type="checkbox"/> tardive dyskinesia	<input type="checkbox"/> No – <i>Submit medical literature documentation supporting the use of tetrabenazine for the beneficiary's diagnosis.</i>	
Is tetrabenazine being prescribed by or in consultation with a neurologist or psychiatrist?		<input type="checkbox"/> Yes <i>If prescriber is not a neurologist, submit documentation of consultation with a neurologist or psychiatrist.</i>	
Did the beneficiary have a mental health evaluation?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of evaluation.</i>	
<b><i>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?</i></b>		<input type="checkbox"/> Yes <i>Submit documentation of evaluation and treatment.</i>	

***For the treatment of tardive dyskinesia, submit documentation of the following as it applies to the beneficiary:***

<input type="checkbox"/> has no other causes of involuntary movement	<input type="checkbox"/> a dose decrease of dopamine receptor blocking agents is not appropriate
<input type="checkbox"/> has documentation of TD severity	<input type="checkbox"/> other therapies for TD are not appropriate

***Requests for non-preferred Xenazine:*** Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred VMAT2 Inhibitors? *Check all that apply.*

<input type="checkbox"/> Austedo	<input type="checkbox"/> Ingrezza	<input type="checkbox"/> tetrabenazine	<input type="checkbox"/> Yes <i>Submit documentation.</i>
			<input type="checkbox"/> No

#### **RENEWAL requests**

Since starting tetrabenazine, did the beneficiary experience an improvement in the medical condition being treated?	<input type="checkbox"/> Yes <i>Submit documentation of beneficiary's response to therapy.</i>
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 tetrabenazine?	<input type="checkbox"/> Yes <i>Submit documentation of evaluation.</i>
<input type="checkbox"/> No	

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

<b>Prescriber Signature:</b>	<b>Date:</b>
------------------------------	--------------

**Confidentiality Notice:** The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.