carolina complete health™

Pharmacy Prior Approval Request for
Movement Disorders: 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. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Continuation Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Does the member have a diagnosis of moderate to severe Huntington's Disease and is experiencing signs and symptoms of chorea? ☐ **Yes** ☐ **No**
2. Is the member age 18 or older? ☐ **Yes** ☐ **No**
3. Is the member beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ **Yes** ☐ **No**
4. Is the member concurrently using a MAOI (monoamine oxidase inhibitor) or reserpine? ☐ **Yes** ☐ **No**
5. Does the member have a history of depression or suicidal ideation? ☐ **Yes** ☐ **No**
6. Is the member receiving treatment and/or is stable? ☐ **Yes** ☐ **No**
7. If prescribing Tetrabenazine, has the member 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. **

Continuation Request (must also answer questions 1-5a above)

1. Has the member met all the above criteria? ☐ Yes ☐ No
2. Has the provider submitted documentation with this request that indicates the member has had an improvement in their symptoms from baseline? ☐ Yes ☐ No

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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/