

**NC 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 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 MAOI (monoamine oxidase inhibitor) 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.