



Date of Request: \_\_\_\_\_

### Sterling Retiree Rx Prior Authorization Form

#### XENAZINE (Tetrabenazine)

**Coverage Criteria**

Chorea associated with Huntington's disease

**Exclusion Criteria**

untreated or inadequately treated depression or actively suicidal; history of hepatic disease or torsade de pointes; use in combination with MAO inhibitors or reserpine (or it has been less than 20 days since reserpine was discontinued).

#### Member Information

|                                  |  |       |  |              |  |
|----------------------------------|--|-------|--|--------------|--|
| Name                             |  |       |  |              |  |
| Enrollment/Card-holder ID Number |  |       |  |              |  |
| Group/Plan                       |  | Male  |  | Female       |  |
| Date of Birth                    |  | Age   |  | Weight in Kg |  |
| Street Address                   |  |       |  |              |  |
| City                             |  | State |  | Zip          |  |

#### Physicians Information

|                  |  |              |  |     |  |
|------------------|--|--------------|--|-----|--|
| Name             |  |              |  |     |  |
| Agent            |  | Contact Name |  |     |  |
| Specialty/Office |  |              |  |     |  |
| Clinic Name      |  |              |  |     |  |
| Street Address   |  |              |  |     |  |
| City             |  | State        |  | Zip |  |
| Phone            |  | Fax          |  |     |  |

#### Requested Drug

|                             |                    |
|-----------------------------|--------------------|
| XENAZINE                    | Reason for Request |
| Condition/Diagnosis Related |                    |

#### Clinical Drug/Lab History Pertinent to Request

| Labs: Baseline/Ongoing                  | Strength/Dosage |
|---|-----------------|
|   |                 |
| Formulary Alternative(s) Attempted?     | Yes:      No:   |
| Please List Alternative Formulary Drugs |                 |
|   |                 |
|   |                 |

|          |
|----------|
| Comments |
|----------|

Physicians Signature: \_\_\_\_\_

Fax Form to 1-866-481-3704