

## XENAZINE PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:			
<b>SECTION A - PATIENT INFORMATION</b>			
First Name:		Last Name:	
Member ID:			
Address:			
City:		State:	
Zip:			
Phone:		DOB:	
Allergies:			
Primary Insurance:		Policy #:	
Group #:			
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>SECTION B - PHYSICIAN INFORMATION</b>			
First Name:		Last Name:	
Address:		City:	
		State:	
		Zip:	
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
<b>SECTION C - MEDICAL INFORMATION</b>			
Medication:			Strength:
Directions for use:			
Diagnosis:		ICD-10 CODE:	Frequency of Administration:
Is Xenazine being prescribed for the treatment of chorea associated with Huntington disease? Yes ___ No ___			
Has the patient's chorea progressed to rigidity and bradykinesia? Yes ___ No ___			
Other pertinent information regarding the request: _____			
_____			
_____			
_____			

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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