UnitedHealthcare Community Plan

XENAZINE PRIOR AUTHORIZATION REQUEST

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

Today's Date:		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:
Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:_____ **Is this patient currently hospitalized? □Yes □No**		

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION		
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: _____