Prescriber Criteria Form

Xenazine 2026 PA Fax 360-A v2 010126.docx
Xenazine (tetrabenazine)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xenazine (tetrabenazine).

Drug Name:
Xenazine (tetrabenazine)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of chorea associated with Huntington's disease? [If no, then skip to question 5.]	Yes	No
2	Is the patient currently receiving therapy with the requested drug? [If yes, then skip to question 10.]	Yes	No
3	Does the patient demonstrate characteristic motor examination features? [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of tardive dyskinesia? [If no, then skip to question 11.]	Yes	No
6	Is the patient currently receiving therapy with the requested drug? [If yes, then skip to question 10.]	Yes	No
7	Does the patient exhibit clinical manifestation of the disease? [If no, then no further questions.]	Yes	No
8	Has the patient's disease been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia	Yes	No

	Identification System: Condensed User Scale [DISCUS])? [If no, then no further questions.]		
9	Has the patient experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine? [No further questions.]	Yes	No
10	Has the patient demonstrated a beneficial response to therapy? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of a tic disorder? [If no, then no further questions.]	Yes	No
12	Is the patient currently receiving therapy with the requested drug?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____