Prescriber Criteria Form Xenazine 2025 PA Fax 360-A v2 010125.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 ANY of the following diagnoses: A) chorea not associated with Huntington's disease, B) a tic disorder, C) hemiballismus? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of chorea associated with Huntington's disease? [If yes, then skip to question 4.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of tardive dyskinesia? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine?	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:**_____