PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual/Optimized** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Tetrabenazine

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Tetrabenazine 12.5 mg tablet ☐ Tetrabenazine 25 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements (initial approval 6 months):

1. Diagnosis of chorea associated with Huntington's disease
2. Cannot be used in combination with Austedo
3. CYP2D6 genotype must be provided for doses greater than 50 mg/day

For continuation, patient must have met the following requirements (indefinite approval if meets continuation criteria after initial 6 months of use):

1. Medical documentation submitted confirming:
    a. Chorea symptoms have improved or stabilized, and
    b. The patient is being monitored for symptoms of depression and, if depression is present, it is being addressed

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax.

Last Updated 07/2017
Last Reviewed 03/2020

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Chorea associated with Huntington's disease
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Will the patient be using in combination with Austedo?

- ☐ Yes, *rationale:* _____
- ☐ No

C. Is the dose requested greater than 50 mg/day?

- ☐ Yes (CYP2D6 genotype must be submitted)
- ☐ No

Request to continue a previously authorized approval
Priority Health Recertification Documentation

A. What condition is this drug being requested for?

- ☐ Chorea associated with Huntington's disease
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Select which of the following apply (medical documentation must be submitted with request):

- ☐ Chorea symptoms have improved or stabilized
- ☐ Patient is being monitored for symptoms of depression

All fields must be complete and legible for review. Your office will receive a response via fax.

Last Updated 07/2017
Last Reviewed 03/2020