Date of Request:____________________

# Sterling Retiree Rx Prior Authorization Form

**XENAZINE (Tetrabenazine)**

**Coverage Criteria**
Chorea associated with Huntington's disease

**Exclusion Criteria**
Untreated or inadequately treated depression; actively suicidal; impaired hepatic function; concomitant use with MAOIs, reserpine or drugs that prolong the QTc interval; non FDA approved use

## Member Information

| Name | | | | | |
|---|---|---|---|---|---|
| Enrollment/Card-holder ID Number | | | | | |
| Group/Plan | | Male | | Female | |
| Date of Birth | | Age | | Weight in Kg | |
| Street Address | | | | | |
| City | | State | | Zip | |

## Physicians Information

| Name | | | | | |
|---|---|---|---|---|---|
| Agent | | Contact Name | | | |
| Specialty/Office | | | | | |
| Clinic Name | | | | | |
| Street Address | | | | | |
| City | | State | | Zip | |
| Phone | | Fax | | | |

## Requested Drug

| XENAZINE | Reason for Request | |
|---|---|---|
| | | |
| Condition/Diagnosis Related | | |

## Clinical Drug/Lab History Pertinent to Request

| Labs: Baseline/Ongoing | Strength/Dosage | | | |
|---|---|---|---|---|
| | | | | |
| Formulary Alternative(s) Attempted? | Yes: | | No: | |
| Please List Alternative Formulary Drugs | | | | |
| | | | | |
| | | | | |
| Comments | | | | |

**Physicians Signature: ________________________________________** **Fax Form to 1-877-847-9904**