BlueCross BlueShield Federal Employee Program

XENAZINE
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

For Standard Option patients GENERIC Xenazine (tetrabenazine) is the preferred product. Please consider prescribing the preferred product. Standard Option patients who switch to generic Xenazine will be eligible for 2 copays at no cost in the benefit year.

Xenazine (tetrabenazine)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**12.5mg** ❑**25mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

How many tablets will the patient need for a 90-day supply? _____ tablet(s) per 90 days

BRAND Xenazine Request (Standard Option Patient): Would you like to switch the patient to the preferred product generic Xenazine (tetrabenazine)? ❑Yes ❑No*

If NO, does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to generic Xenazine (tetrabenazine)? ***Please select answer below:***

❑ **Yes** ***(please specify)***: _____

❑ **No**: Is there a clinical reason for not trying generic Xenazine (tetrabenazine)? ❑Yes* ❑No

If YES, please specify: _____

GENERIC Xenazine Request (Standard Option Patient): Is generic Xenazine (tetrabenazine) being requested from brand Xenazine so the member can access their copay benefit? ❑Yes ❑No

1. What is the patient's diagnosis?
   - ❑Acute dystonia due to drugs
   - ❑Dystonia
   - ❑Huntington's chorea
   - ❑Other chorea
   - ❑Orofacial dyskinesia
   - ❑Subacute dyskinesia due to drugs (tardive dyskinesia or TD)
   - ❑Tourette's disorder
   - ❑Other diagnosis ***(please specify):*** _____
2. Is the patient actively suicidal? ❑Yes ❑No
3. Does the patient have untreated or inadequately treated depression? ❑Yes ❑No
4. Is the patient taking an MAOI (monoamine oxidase inhibitor)? ❑Yes ❑No
5. Is the patient **CURRENTLY** taking reserpine? ❑Yes ❑No*
   If NO, has the patient been on reserpine in the **PAST** 20 days? ❑Yes ❑No
6. Does the patient have severe hepatic impairment? ❑Yes ❑No
7. Will Xenazine be used in combination with another *vesicular monoamine transporter 2 (VMAT2) inhibitor? ❑Yes ❑No
   ****VMAT2 Inhibitors: deutetrabenazine (Austedo), valbenazine (Ingrezza)***

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***