



Physician's Prior Authorization Questionnaire for Xenazine®

PATIENT'S NAME: _____ ID#: _____ DOB: _____

Patient Address: _____

Xenazine® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis (no codes please)? _____
2. Does the patient exhibit chorea symptoms? ___Yes ___No
3. Is the patient actively suicidal? ___Yes ___No
4. Does the patient have untreated or inadequately treated depression? ___Yes ___No
5. Does the patient have impaired liver function? ___Yes ___No
6. Is the patient currently taking monoamine oxidase inhibitors? ___Yes ___No
7. Is the patient currently taking reserpine? ___Yes ___No

Quantity limits will be applied according to the dosing listed in the manufacturer's prescribing information. Coverage will not be available for more than one (1) month's supply at a time. Xenazine® will be shipped to the patient from our Specialty Pharmacy vendor.

Physician's Signature	Date
Please <u>Print</u> Name	Fax Number
Please <u>Print</u> Physician's Specialty	Phone Number

Thank you for your assistance. Please contact Arkansas Blue Cross and Blue Shield at (501) 378-3392 if you have any questions or concerns. You also may fax your response(s) back to Arkansas Blue Cross at (501) 378-6980.

Sincerely,
Pharmacy Programs
Forms are also available online at <http://usableadmin.abcbs.net/providers/PharmacyForms.aspx>