Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Xenazine (FA-PA)

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 **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xenazine (FA-PA).

Drug Name (select from list of drugs shown)
Xenazine (tetrabenazine)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Has the patient failed treatment with the generic medication due to an intolerable adverse event (e.g., rash, nausea, vomiting)?	Y N
2.	Was the intolerable adverse event an expected adverse event attributed to the ACTIVE ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)?	Y N
3.	Was this documented in the patient's chart? Documentation is required for approval. Provide SPECIFIC AND DETAILED chart documentation including description, date/time, and severity of the adverse event,	Y N

dosage and duration of generic medication treatment, required intervention (if any), and relevant tests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date