



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Xenazine (Medicare Prior Auth)**

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 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xenazine (Medicare Prior Auth).

Drug Name (select from list of drugs shown)
Xenazine

Patient Information

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

Prescribing Physician

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

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|--|---|---|
| 1. Does the patient have chorea associated with Huntington's disease? | Y | N |
| 2. Is the patient actively suicidal or has untreated or inadequately treated depression?
[If the answer to this question is yes, then no further questions.] | Y | N |
| 3. Does the patient have impaired hepatic function?
[If the answer to this question is yes, then no further questions.] | Y | N |
| 4. Will Xenazine be used concomitantly with monoamine oxidase inhibitors?
[If the answer to this question is yes, then no further questions.] | Y | N |
| 5. Is the patient currently taking reserpine or has the patient taken reserpine in the past 20 days?
[If the answer to this question is no, then no further questions.] | Y | N |
| 6. Will the patient wait at least 20 days after stopping reserpine before initiating Xenazine therapy? | Y | N |

Comments: _____



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

Prescriber (Or Authorized) Signature and Date