Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Movement Disorders: Xenazine / tetrabenazine (generic)

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (in days): **Initial Request**: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days
Continuation Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Does the member have a diagnosis of moderate to severe Huntington's disease and is experiencing signs and symptoms of chorea? ☐ **Yes** ☐ **No**
2. Is the member age 18 or older? ☐ **Yes** ☐ **No**
3. Is the member receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ **Yes** ☐ **No**
4. Is the member concurrently using a MAOI (monoamine oxidase inhibitor) or reserpine? ☐ **Yes** ☐ **No**
5. Does the member have a history of depression or suicidal ideation? ☐ **Yes** ☐ **No**
6. Is the member receiving treatment and/or is stable? ☐ **Yes** ☐ **No**
7. If prescribing Tetrabenazine, has the member tried and failed ONE preferred drug in the same class? ☐ **Yes** ☐ **No**

**For Continuation of Therapy, attach documentation that indicates the member has had an improvement in their symptoms from baseline. **

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.