OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (check applicable drug below)

❑ **Xenazine®** (tetrabenazine)	❑ **tetrabenazine**

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

Drug Name/Form: _____

Drug Strength: _____ **Dosing Schedule:** _____

Length of Therapy: _____ **ICD Code, if applicable:** _____

Diagnosis: _____

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

❑ **For Xenazine® approval:**

- ❑ Medication is prescribed by or in consultation with a Neurologist; **AND**
- ❑ Patient **MUST** have a diagnosis of chorea associated with Huntington's Disease **(chart notes must document diagnostic criteria and symptoms)**; **AND**
- ❑ Patient must have trial and failure of **at least 30 days** of tetrabenazine **(chart notes must document therapy failure)**

❑ **For tetrabenazine approval:**

- ❑ Medication is prescribed by or in consultation with a Neurologist; **AND**
- ❑ Patient **MUST** have a diagnosis with chorea associated with Huntington's Disease **(chart notes must document diagnostic criteria and symptoms)**

Medication being provided by a Specialty Pharmacy - PropriumRx

(continued on next page; signature page must be attached to this request form)

(**Signature page MUST be included with request form)**

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 7/19/18
REVISED/UPDATED: ~~9/28/2018;~~ **(Reformatted) 7/9/2019**;