

Xenazine[®] Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Memb	Provider Information (required)						
Member Name:			Provider Name:				
Insurance ID#:			NPI#:	Specialty:			
Date of Birth:			Office Phone:				
Street Address:	Office Fax:						
City:	State:	Zip:	Office Street Address:				
Phone:			City:	State:		Zip:	
Medication Information (required)							
Medication Name:			Strength:		Dosage Form:		
Check if requesting brand			Directions for Use:				
Check if request is							
Clinical Information (required)							
Clinical information:							
Does the patient have a confirmed diagnosis of chorea associated with Huntington's disease? D Yes D No							
Is the requested medication prescribed by or in consultation with a neurologist or psychiatrist? Yes No							

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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