Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Tetrabenazine - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient currently receiving tetrabenazine therapy?

☐ Yes ☐ No

Q2. Has the patient been approved for treatment with tetrabenazine?

☐ Yes ☐ No

Q3. Does the member have documented improvement in symptoms of chorea with medical records attached?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is tetrabenazine being prescribed by or in consultation with neurologist or psychiatrist?

☐ Yes ☐ No

Q6. Is there documentation that other movement disorders (such as tardive dyskinesia or Parkinson's disease) have been excluded?
Documentation must be attached.

☐ Yes ☐ No

Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Tetrabenazine - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q7. Is there documentation attached showing confirmation of a diagnosis of chorea associated with Huntington's disease? Documentation must be attached.

☐ Yes ☐ No

Q8. Have all potential contraindications (including congenital long QT syndrome, history of cardiac arrhythmias,hepatic impairment,concurrent use of reserpine, deutetrabenazine, or valbenazine, associated with prolonged QT interval, and actively suicidal patients and patients with untreated or inadequately treated depression) been excluded?

☐ Yes ☐ No

Q9. Will the patient be treated concomitantly with a monoamine oxidase (MAO) inhibitor?

☐ Yes ☐ No

Q10. Additional Information:

Q11. Duration:

☐ 12 Months ☐ Other

Prescriber Signature

Date

2024 Medicare Prior Authorization Request