Jefferson Health Plans

MEDICARE ADVANTAGE
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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 request for reauthorization of tetrabenazine? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Does the member have documented improvement in symptoms of chorea with medical records attached?

☐ Yes ☐ No

Q3. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q4. Is tetrabenazine being prescribed by or in consultation with neurologist or psychiatrist?

☐ Yes ☐ No

Q5. Is there documentation attached that other movement disorders (such as tardive dyskinesia or Parkinson's disease) have been excluded? Documentation must be attached.

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Is there documentation attached showing confirmation of a diagnosis of chorea associated with Huntington's disease? Documentation must be attached.

☐ Yes ☐ No

Q7. Have all potential contraindications (including congenital long QT syndrome, history of cardiac arrhythmias, hepatic impairment, concurrent use of reserpine, deutetrabenazine, or valbenazine, and actively suicidal patients and patients with untreated or inadequately treated depression) been excluded?

☐ Yes ☐ No

Q8. Will the patient be treated concomitantly with a monoamine oxidase (MAO) inhibitor?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other:

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2026