

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 he 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



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:
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

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

v2026