

VMAT2 INHIBITORS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Chorea associated with Huntington's disease <input type="checkbox"/> Tardive dyskinesia <input type="checkbox"/> Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

- For all requests:**
1. Is the patient currently treated with the requested agent? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required** Yes No
 2. Will the patient be using the requested agent in combination with another VMAT2 Inhibitor agent? Yes No
 3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., psychiatrist, neurologist), or has the prescriber consulted with a specialist? Yes No
 4. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____
 5. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
 6. Has the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
 7. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** Yes No
 8. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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9. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For tardive dyskinesia requests:

10. Is the patient taking any medications known to cause tardive dyskinesia (i.e., dopamine receptor blocking agents)? Yes No
 If yes, has the prescriber reduced the dose or discontinued any medications known to cause tardive dyskinesia?..... Yes No
 If no, is a reduced dose or discontinuation of any medications known to cause tardive dyskinesia not appropriate? Yes No
 If yes, please explain _____

11. Has the patient's tardive dyskinesia been evaluated through clinical examination or through a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS])? Yes No

For brand Xenazine requests:

- **Please submit chart notes to support the answers to the following questions:**

12. Has the patient tried and had an inadequate response to generic tetrabenazine? Yes No
 13. Was generic tetrabenazine discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 14. Does the patient an intolerance or hypersensitivity to generic tetrabenazine that is not expected to occur with the requested brand agent? Yes No
 15. Does the patient an FDA labeled contraindication to generic tetrabenazine that is not expected to occur with the requested brand agent? Yes No
 16. Is generic tetrabenazine expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
 17. Is generic tetrabenazine not in the best interest of the patient based on medical necessity? Yes No
 18. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic tetrabenazine and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For renewal requests:

19. Has the patient had clinical benefit with the requested agent? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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