

XENAZINE

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Does the patient have chorea associated with Huntington's disease? Y N
2. Is the patient actively suicidal, or has untreated or inadequately treated depression?
[If the answer to this question is yes, no further questions are required.] Y N
3. Does the patient have impaired hepatic function?
[If the answer to this question is yes, no further questions are required.] Y N
4. Will Xenazine be used concomitantly with monoamine oxidase inhibitors?
[If the answer to this question is yes, no further questions are required.] Y N
5. Is the patient currently taking reserpine or has the patient taken reserpine in the past 20 days?
[If the answer to this question is no, no further questions are required.] Y N
6. Will the patient wait at least 20 days after stopping reserpine before initiating Xenazine therapy? Y N

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Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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