FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Austedo®, Xenazine®, & tetrabenazine
Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		Office Contact:
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.

Quantity per DAY requested? _________

Select the diagnosis below:

❑ Chorea associated with Huntington's disease

❑ Tardive dyskinesia (TD)

❑ Other diagnosis: ____ ICD-10 Code(s): ______________________________________

Prescriber's Specialty:

Is the requested medication prescribed by or in consultation with a neurologist or a psychiatrist? ❑ **Yes** ❑ **No**

For tardive dyskinesia (TD), also answer the following:

Is the patient a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication? ❑ **Yes** ❑ **No**

Does the patient have persistent symptoms of TD despite a trial of dose reduction, tapering, or discontinuation of the offending medication? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Medication History:

For brand Xenazine, select if the patient has a history of trial and failure, or intolerance to the following:

❑ Austedo

❑ Generic tetrabenazine

❑ Other drugs in the same class. Please specify: ____

❑ Other therapeutic equivalent alternatives. Please specify: ____

Quantity Limit Requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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