



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Xenazine

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Xenazine Other _____
2. What is the diagnosis? Chorea associated with Huntington's disease Other _____
3. Does the patient have porphyria? Yes No
4. What is the medical specialty of the prescribing physician? Retinal specialist Other _____
5. Will the prescribed agent used as monotherapy? Yes No
6. Is the patient currently receiving Xenazine? Yes No **If No, skip to Diagnosis Section*
7. Has the patient been evaluated for choroidal neovascular leakage as detected on fluorescein angiography? Yes No
8. Has the patient experienced efficacy with prior treatment? Yes No
9. **Attach documentation to support prior treatment efficacy.**

Complete the Section below designated for the patient's diagnosis

Section A: Occult choroidal neovascularization (CNV)

10. Is occult CNV due to age-related macular degeneration? Yes No
11. What is the patient's vision? Less than 20/50 Greater than 20/50 Vision not available
12. Is occult CNV less than 4 macular photocoagulation study (MPS) disc areas in size? Yes No

Section B: Subfoveal classic choroidal neovascularization (CNV)

13. Is subfoveal classic CNV due to one of the following? Yes No
 Age-related macular degeneration Pathological myopia Presumed ocular histoplasmosis

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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