



Fax Referral To: 800-323-2445  
 Phone: 866-278-6634

# Xenazine® (tetrabenazine)

## Enrollment Form

### For Blue Cross Blue Shield of Rhode Island Members

Date: \_\_\_\_\_ Needs by Date (Please Specify): \_\_\_\_\_

Ship to:  Patient  Office  Other: \_\_\_\_\_

**PATIENT INFORMATION**

*(Complete the following or send patient demographic sheet)*

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 Last Four of SS #: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Insurance ID: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's Name: \_\_\_\_\_  
 State License #: \_\_\_\_\_ UPIN: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Group or Hospital: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_  
 Contact Phone: \_\_\_\_\_

**INSURANCE INFORMATION** *(Please copy and attach the front and back of insurance and prescription drug card)*

**Prescription Card:** Name of Insurer: \_\_\_\_\_ ID#: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_ Group: \_\_\_\_\_  
**Primary Insurance:** Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Name of Insurer: Blue Cross Blue Shield of RI Phone: \_\_\_\_\_  
**Secondary Insurance:** Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_ Phone: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members**

**Diagnosis (ICD-9 Code):**  \_\_\_\_\_ • Date of Diagnosis: \_\_\_\_\_

**Approval Criteria: CHECK ALL BOXES THAT APPLY**

**Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST**

- Patient has a diagnosis of chorea associated with Huntington's Disease.  Yes  No
- Is the requested quantity more than 4 tablets (12.5 mg) or 2 tablets (25mg) per day?  Yes  No
- Is the prescribed dose more than 50 mg per day?  Yes  No
  - If yes, has the patient been tested for CYP 2D6 genotype?  Yes  No
  - Is the patient a poor metabolizer of CYP 2D6?  Yes  No
  - Is the requested quantity more than 8 tablets (12.5 mg) or 4 tablets (25 mg) per day?  Yes  No

**PRESCRIPTION INFORMATION**

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY (per 30 days)	REFILLS
<input type="checkbox"/> Xenazine® (tetrabenazine)	<input type="checkbox"/> 12.5mg <input type="checkbox"/> 25mg	_____ _____		

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
 PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

**IMPORTANT NOTICE:** This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Xenazine PAB 122011