



Prescription Drug Coverage Determination Form
Central Monoamine-Depleting Agent
Xenazine® (tetrabenazine)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: _____ Date of Birth: _____
Subscriber ID#: _____
Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
Office Address _____ City _____ State _____ Zip Code _____
Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for
members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
Dose: _____ Directions: _____
Expected Duration of Therapy: _____

Prior Authorization Criteria:

- 1. Is the medication being requested to treat an FDA-approved indication not otherwise
excluded from Part D?
Diagnosis: _____ ICD-9 code _____
2. Will the physician be monitoring the patient for evidence of depression and/or active
suicidal ideation?
3. Does the patient have impaired hepatic function?
4. Is the patient currently using a monoamine oxidase inhibitor or reserpine?
If yes:
- Will the patient discontinue the medication at least 20 days prior to the
initiation of Xenazine® therapy?

Please provide any additional history or medical information that may support coverage
(attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.