

**PREAUTHORIZATION FORM**  
Xenazine<sup>®</sup>  
(tetrabenazine)

**Therapeutic use:** Treatment of chorea associated with Huntington disease

**Quantity Limit:** 4 tablets per day; available as 12.5 mg and 25 mg tablets

**Authorization Period:** 12 months

Patient's name \_\_\_\_\_

Patient's ID#  DOB  /  /

ICD-9

Physician's name \_\_\_\_\_

Physician's Ph# (  )  -  Fax#  -

Physician's signature \_\_\_\_\_ Date signed  /  /

Supervising Physician's name \_\_\_\_\_ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:

1.	Is the prescribing physician a neurologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Has the patient diagnosed with Huntington Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.**