

VESICULAR MONOAMINE TRANSPORTER 2 (VMAT2) INHIBITORS

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit

<https://www.bcbstx.com/provider/medicaid/pharmacy/star-kids-prior-auth>

PATIENT AND INSURANCE INFORMATION

Today's Date: _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:		City, State, Zip:	Patient Telephone:
BCBSTX ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when was treatment with the requested medication started? _____	
2. Does the patient have a diagnosis of Huntington-induced Chorea in the last 365 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Does the patient have a diagnosis of tardive dyskinesia in the last 365 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Does the patient have a diagnosis of severe depression or suicide attempt/ideation in the last 180 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Will the patient have concurrent therapy with another VMAT2 inhibitor (other than requested agent)?	
6. Does the patient have a diagnosis of hepatic impairment in the last 365 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Has the patient taken an MAO inhibitor or a strong CYP3A4 inducer in the last 90 days?	
8. Does the patient have a diagnosis of long QT syndrome in the last 365 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Please list the medications the patient has previously tried and failed for treatment of this diagnosis (Please specify if brand name, generic, extended-release products, or over-the-counter products): _____ Date(s): _____ Date(s): _____ _____ Date(s): _____ Date(s): _____ _____	
10. Please list all reasons for selecting the requested medication over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). _____ _____	
11. Please list all other medications the patient is currently taking for treatment of this diagnosis. _____ _____	

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:

Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road, Suite 200
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 Phone: 855.457.1200

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