



**HUNTINGTON'S DISEASE  
MEDICATIONS  
(FOR XENAZINE® REQUEST)  
New Hampshire Medicaid Prior Authorization  
Request Form**



**Fax: 1-888-603-7696    Phone: 1-866-675-7755**

Date of Medication Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section I: Patient Information and Medication Requested:**

Name: (Last, First) _____	NH Medicaid Number: _____
Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

**Section II: Clinical History:**

1. Does the patient have a diagnosis of Huntington's Chorea?  Yes     No

2. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

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**Section III: Prescriber Information:**

Name: _____	NPI Number: _____
Phone Number: (____) _____ - _____	Fax Number: (____) _____ - _____

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

\_\_\_\_\_  
**Signature of Prescribing Provider**