

AUSTEDO (deutetrabenazine) (non-preferred) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **VMAT2 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on the Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:	NPI:	MA Provider ID#:	
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	<input type="checkbox"/> Austedo tablet (non-preferred)	<input type="checkbox"/> Austedo _____	Strength:
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx codes (<i>required</i>):	

ALL requests

1. Do any of the following contraindications apply to the beneficiary? <i>Check all that apply.</i> <input type="checkbox"/> actively suicidal <input type="checkbox"/> taken an MAO inhibitor in the past 14 days <input type="checkbox"/> hepatic impairment <input type="checkbox"/> taken reserpine in the past 20 days <input type="checkbox"/> taking Xenazine or Ingrezza <input type="checkbox"/> depression that is untreated or inadequately treated	<input type="checkbox"/> Yes <i>Submit supporting documentation, including liver function test (LFT) results, mental health evaluation, and medication list.</i> <input type="checkbox"/> No
2. <u>If the beneficiary is known to be a poor CYP2D6 metabolizer or will be taking a strong CYP2D6 inhibitor (such as bupropion, fluoxetine, paroxetine, or quinidine), will the dose of Austedo be adjusted accordingly?</u>	<input type="checkbox"/> Yes <i>Submit documentation of dosing and beneficiary's complete medication list.</i> <input type="checkbox"/> No

INITIAL requests

1. Does the beneficiary have one of the following diagnoses? <input type="checkbox"/> chorea associated with Huntington's disease <input type="checkbox"/> tardive dyskinesia	<input type="checkbox"/> Yes – <i>Submit documentation supporting beneficiary's diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature documentation supporting the use of Austedo for the beneficiary's diagnosis.</i>
2. Is Austedo being prescribed by or in consultation with a neurologist or psychiatrist?	<input type="checkbox"/> Yes <i>If prescriber is not a neurologist or psychiatrist, submit documentation of consultation with a neurologist or psychiatrist.</i> <input type="checkbox"/> No
3. Does the beneficiary have a history of trial and failure of, or contraindication or intolerance to, the preferred agent in this class, Xenazine ?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
4. Did the beneficiary have a mental health evaluation?	<input type="checkbox"/> Yes <i>Submit documentation of evaluation.</i> <input type="checkbox"/> No
5. <u>If the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder,</u> was the beneficiary evaluated in the past 6 months and treated by a psychiatrist?	<input type="checkbox"/> Yes <i>Submit documentation of evaluation and treatment.</i> <input type="checkbox"/> No
6. <u>For the treatment of tardive dyskinesia,</u> submit documentation of the following as it applies to the beneficiary: <input type="checkbox"/> has no other causes of involuntary movement <input type="checkbox"/> a dose decrease of dopamine receptor blocking agents is not appropriate <input type="checkbox"/> has documentation of TD severity <input type="checkbox"/> other therapies for TD are not appropriate	

RENEWAL requests

1. Since starting Austedo, did the beneficiary experience an improvement in the medical condition being treated?	<input type="checkbox"/> Yes <i>Submit documentation of beneficiary's response to therapy.</i> <input type="checkbox"/> No
2. Was the beneficiary reevaluated (and treated, if applicable) for new onset or worsening symptoms of depression and determined to be a candidate for treatment with Austedo?	<input type="checkbox"/> Yes <i>Submit documentation of evaluation.</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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