

### AUSTEDO (deutetrabenazine) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **VMAT2 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

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

#### **CLINICAL INFORMATION**

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

#### **ALL requests**

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
<b><i>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?</i></b>	<input type="checkbox"/> Yes <i>Submit documentation of dosing and beneficiary's complete medication list.</i> <input type="checkbox"/> No

#### **INITIAL requests**

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>
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
Did the beneficiary have a mental health evaluation?	<input type="checkbox"/> Yes <i>Submit documentation of evaluation.</i> <input type="checkbox"/> No
<b><i>If the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder, was the beneficiary evaluated in the past 6 months and treated by a psychiatrist?</i></b>	<input type="checkbox"/> Yes <i>Submit documentation of evaluation and treatment.</i> <input type="checkbox"/> No

***For the treatment of tardive dyskinesia, 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**

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
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**

<b>Prescriber Signature:</b>	<b>Date:</b>
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