pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

VMAT2 INHIBITORS PRIOR AUTHORIZATION FORM *(form effective 2/1/2022)*

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.

☐New request ☐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:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:
☐Austedo tablet ☐tetrabenazine tablet
☐Ingrezza capsule ☐Xenazine tablet *(submit documentation showing why generic tetrabenazine cannot be used)*
☐Ingrezza initiation pack ☐_____

Strength:	Quantity:	Refills:
Dose/directions:		
Diagnosis *(submit documentation)*:		Dx codes (*required*):
Is the requested medication being prescribed by or in consultation with a specialist (ie., neurologist or psychiatrist)?		☐Yes ☐No *Submit documentation of consultation if applicable.*

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐For AUSTEDO (DEUTETRABENAZINE):
- ☐Has a contraindication to Austedo *(check all that apply)*:
  - ☐Actively suicidal
  - ☐Hepatic impairment
  - ☐Taking Xenazine or Ingrezza
  - ☐Taken an MAO inhibitor in the past 14 days (eg, phenelzine, rasagiline, selegiline, tranylcypromine)
  - ☐Taken reserpine in the past 20 days
  - ☐Depression that is untreated or inadequately treated
- ☐Is known to be a poor CYP2D6 metabolizer
  - ☐Austedo dose is adjusted accordingly based on dosing recommendations in the package labeling
- ☐Will be taking a strong CYP2D6 inhibitor while taking Austedo (e.g., bupropion, fluoxetine, paroxetine, quinidine)
  - ☐Austedo dose is adjusted accordingly based on dosing recommendations in the package labeling

☐For INGREZZA (VALBENAZINE):
- ☐Is taking a strong CYP3A4 inhibitor (eg, some azole antifungals, nefazodone, some protease inhibitors)
  - ☐Ingrezza dose is adjusted accordingly based on dosing recommendations in the package labeling
- ☐Is taking a strong CYP2D6 inhibitor (eg, bupropion, fluoxetine, paroxetine, quinidine)
  - ☐Ingrezza dose is adjusted accordingly based on dosing recommendations in the package labeling
- ☐Has moderate or severe hepatic impairment (Child-Pugh score 7 to 15)

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- ☐ Ingrezza dose is adjusted accordingly based on dosing recommendations in the package labeling
- ☐ Is taking a strong CYP3A4 inducer (eg, carbamazepine, phenytoin, rifampin, St. John's Wort) *(concomitant use not recommended per package labeling)*

☐ For TETRABENAZINE / XENAZINE:

- ☐ Has a contraindication to tetrabenazine / Xenazine *(check all that apply)*:
  - ☐ Actively suicidal
  - ☐ Hepatic impairment
  - ☐ Taking Austedo or Ingrezza
  - ☐ Taken an MAO inhibitor in the past 14 days (eg, phenelzine, rasagiline, selegiline, tranylcypromine)
  - ☐ Taken reserpine in the past 20 days
  - ☐ Depression that is untreated or inadequately treated
- ☐ Will be taking a strong CYP2D6 inhibitor while taking tetrabenazine (eg, bupropion, fluoxetine, paroxetine, quinidine)
  - ☐ Tetrabenazine dose is adjusted accordingly based on dosing recommendations in the package labeling
- ☐ Is prescribed a tetrabenazine dose that exceeds 50 mg per day
  - ☐ Has documentation of therapeutic failure of tetrabenazine at a dose of ≤50 mg/day
  - ☐ Has documentation of CYP450 2D6 genotyping showing intermediate or extensive metabolism

INITIAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Had a mental health evaluation

- ☐ Has a history of suicide attempt, bipolar disorder, or major depressive disorder
  - ☐ Was evaluated in the past 6 months and treated by a psychiatrist
- ☐ Was determined to be a candidate for treatment with the requested medication based on the mental health evaluation

☐ For treatment of TARDIVE DYSKINESIA:

- ☐ Has no other causes of involuntary movement
- ☐ Has documentation of tardive dyskinesia severity using a validated scale or assessment of impact on daily function
- ☐ A decrease in dose of dopamine receptor blocking agents is not appropriate

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Was reevaluated for new onset or worsening symptoms of depression

- ☐ If applicable, was or is being treated for symptoms of depression

☐ Was determined to remain a candidate for treatment with the requested medication based on the mental health evaluation

☐ For treatment of CHOREA:

- ☐ Experienced clinical benefit from the requested medication based on the prescriber's clinical judgement

☐ For treatment of TARDIVE DYSKINESIA:

- ☐ Experienced an improvement in tardive dyskinesia severity documented by a validated scale
- ☐ Experienced an improvement in daily functioning

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

Prescriber Signature:	Date: