Updated: 07/2019
PARP Approved: 07/2019

Prior Authorization Criteria

Austedo (deutetrabenazine) and Ingrezza (valbenazine)

All requests for Austedo (deutetrabenazine) and Ingrezza (valbenazine) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests for Austedo (deutetrabenazine) and Ingrezza (valbenazine) all of the following criteria must be met:

- The member must be 18 years of age or older
- Must be prescribed by or in consultation with a neurologist or psychiatrist (for tardive dyskinesia)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member must not have a contraindication to the requested medication

Coverage may be provided with a diagnosis of chorea associated with Huntington's disease and the following criteria is met:

- The request is for Austedo (deutetrabenazine) only
- Documentation of a baseline Total Chorea Score
- Documentation of contraindication, intolerance or inadequate response to at least 12 weeks of tetrabenazine treatment

Coverage may be provided with a diagnosis of tardive dyskinesia and the following criteria is met:

- The request is for Austedo (deutetrabenazine) or Ingrezza (valbenazine)
- Documentation of a baseline (Abnormal Involuntary Movement Scale) AIMS score (prior to deutetrabenazine therapy)
- Documentation of treatment with a dopamine receptor antagonist (e.g. antipsychotic, metoclopramide etc.) in the past 3 months

- **Initial Duration of Approval**:
    - For chorea associated with Huntington's disease: 12 months
    - For tardive dyskinesia: 6 months

- **Reauthorization Criteria:**
    - For chorea associated with Huntington's disease
        - First reauthorization criteria (member on therapy for 0 to 12 months)
            - Must have documentation from the prescriber indicating improvement in condition

- Documentation of a current Total Chorea Score (within 12 months of initiating therapy) showing a decrease in the Total Chorea Score since initiation of therapy
- Subsequent reauthorization criteria (member on therapy ≥ 12 months)
  - Must have documentation from the prescriber indicating stabilization or improvement in condition
  - Documentation of a current Total Chorea Score (within last 12 months)

- For tardive dyskinesia
  - First reauthorization criteria (member on therapy for 0 to 6 months)
    - Must have documentation from the prescriber indicating improvement in condition
    - Documentation of a current AIMS score (within last 3 to 6 months since initiating therapy) showing a decrease in AIMS score since initiation of Austedo or Ingrezza
  - Subsequent reauthorization criteria (member on therapy ≥ 6 months)
    - Must have documentation from the prescriber indicating stabilization or improvement in condition
    - Documentation of a current AIMS score (within last 12 months)

- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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AUSTEDO (DEUTETRABENAZINE)/INGREZZA (VALBENAZINE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Member's Diagnosis: ☐ Chorea associated with Huntington's Disease ☐ Tardive Dyskinesia ☐ Other _____

If requesting for Chorea associated with Huntington's disease, please provide the member's baseline Total Chorea Score _____ Date Obtained _____

If requesting for Tardive Dyskinesia, please provide the member's baseline AIMS score _____Date Obtained_____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No

Please describe:

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Member Name: **DOB:**
Member ID:

For Initial Reauthorization:

Please provide current (within 3 to 6 months of starting therapy) AIMS score _____Date Obtained_____

OR

Please provide current (within 12 months of starting therapy) Total Chorea Score _____Date Obtained_____

For Subsequent reauthorizations

Please provide a Current (within last 12 months) AIMS score _____

Date Obtained _____

Please provide a Current (within last 12 months) Total Chorea Score _____

Date Obtained _____

SUPPORTING INFORMATION or CLINICAL RATIONALE	
Prescribing Provider Signature	Date