Updated: 04/2024
DMMA Approved: 04/2024

Request for Prior Authorization for Austedo (deutetrabenazine) and Ingrezza (valbenazine)

Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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

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

- 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:

- For a non-preferred agent documentation the member has tried and failed (for at least 6 weeks) or has a contraindication or intolerance to a preferred agent
- Documentation of treatment with a dopamine receptor antagonist (e.g. antipsychotic, metoclopramide etc.) in the past 3 months
- Documentation of a baseline Abnormal Involuntary Movement Scale (AIMS) Score.
- **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
        - 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
        - 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.

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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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8 am to 7 pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

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

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY

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

For Chorea associated with Huntington's disease:
Member's baseline Total Chorea Score _____ Date Obtained _____

For Tardive Dyskinesia:
Member's baseline AIMS score _____ Date Obtained_____

REAUTHORIZATION

Has the member had stabilization or improvement in the condition? Yes ☐ No ☐
Current (within last 12 months) AIMS score _____ Date Obtained _____
Current (within last 12 months) Total Chorea Score _____ Date Obtained _____

HIGHMARK HEALTH OPTIONS

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Member Name:	DOB:
Member ID:	

PREVIOUS THERAPY			
Medication Name	**Strength/Frequency**	**Dates of Therapy**	**Status (Discontinued & Why or Current)**

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature	Date