Updated: 08/2022
DMMA Approved: 08/2022

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

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

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)
- 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)

o 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.

HIGHMARK HEALTH OPTIONS

Updated: 08/2022
DMMA Approved: 08/2022

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 _____

Member Name:	DOB:

HIGHMARK HEALTH OPTIONS

Updated: 08/2022
DMMA Approved: 08/2022

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**