OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct**. Incomplete form will delay authorization process.**

Drug Requested: Austedo™ (deutetrabenazine)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

CLINICAL CRITERIA: **ALL** information below **MUST** be checked to qualify or authorization process will be delayed. Chart note, lab results, and/or any testing/score **MUST** be submitted with this request.

❑ **DIAGNOSIS: Huntington's Disease (must** be checked to qualify or authorization will be delayed.)

Initial Approval – Length of approval is for **12 months**. Dose may not exceed 48 mg/day. Concomitant use with tetrabenazine will **NOT** be approved.

- ❑ Prescriber is or in consultation with a Neurologist
- ❑ Patient is ≥ 18 years of age, **AND**
- ❑ Diagnosed with chorea associated with Huntington's Disease **AND**
- ❑ Trial and failure of **at least 30 days** with tetrabenazine **AND**
- ❑ Patient is **NOT** actively suicidal and does not have any of the following:
  - ❑ untreated or inadequately treated depression
  - ❑ concomitant use of MAOI medication
  - ❑ hepatic impairment

Reauthorization Approval for Huntington's Disease: Length of approval is for **12 months**, not to exceed 48 mg/day. Chart notes and required testing **MUST** be submitted with this request form.

- ❑ Chorea symptoms **MUST** have improved or stabilized **AND**
- ❑ Member is **NOT** actively suicidal and does **NOT** have any of the following:
  - ❑ untreated or inadequately treated depression
  - ❑ concomitant use of MAOI medication
  - ❑ hepatic impairment

❑ **DIAGNOSIS: Tardive Dyskinesia (must be checked to qualify or authorization process will be delayed.**

Initial Approval – Length of approval is for **3 months.** Dose may not exceed 48 mg/day. Chart notes and required testing **MUST** be submitted with this request form**.**

❑ Prescriber is: ❑ Neurologist ❑ Psychiatrist **AND**

(continued on next page)

- ❑ Patient is ≥ 18 years of age **AND**
- ❑ Patient has a diagnosis of moderate to severe tardive dyskinesia, meeting all DSM-5 diagnostic criteria **(chart notes MUST be attached)** **AND**
  - ❑ Involuntary athetoid or choreiform movements **AND**
  - ❑ History of treatment with dopamine receptor blocking agent (DRBA) **(Claims history or chart notes must be attached)** **AND**
  - ❑ Symptom duration has lasted more than 4 to 8 weeks **AND**
- ❑ Documentation that AIMS test has been completed to obtain baseline evaluation **(testing or score must be attached).** One of the following criteria exists:
  - ❑ Persistence symptoms of tardive dyskinesia despite a trial dose reduction, tapering, or discontinuation of the offending agent **OR**
  - ❑ Member is **NOT** a candidate for a trial dose reduction, tapering, or discontinuation of the offending agent **OR**
  - ❑ Member is **NOT** actively suicidal and does **NOT** have any of the following:
    - ❑ untreated or inadequately treated depression
    - ❑ concomitant use of MAOI medication
    - ❑ hepatic impairment

Reauthorization Approval for Tardive Dyskinesia Diagnosis: Length of continued approval is for **12 months**, not to exceed 48 mg/day. Chart notes and required testing **MUST** be submitted with this request form.

- ❑ Documentation of positive clinical response to Austedo™ therapy **(chart notes MUST be attached)** **AND**
- ❑ Improvement in current AIMS score compared to baseline submission **(testing or score must be attached)**

AND

- ❑ Member is **NOT** actively suicidal and does **NOT** have any of the following:
  - ❑ untreated or inadequately treated depression
  - ❑ concomitant use of MAOI medication
  - ❑ hepatic impairment

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~4/6/2018; 6/3/2018; 8/16/2018;~~ **9/28/2018**