

OPTIMA HEALTH COMMUNITY CARE

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 1-844-348-3720. 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) **(Medical)**

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 process 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 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
- Patient is ≥ 18 years of age **AND**
- Patient has a diagnosis of moderate to severe tardive dyskinesia, meeting all DSM-5 diagnostic criteria **AND**
- Involuntary athetoid or choreiform movements **AND**

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- 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
 - 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 **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