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 1-800-319-5003. 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 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**

(continued on next page)

- ❑ 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;~~ **6/3/2018**