

**Request for Prior Authorization
 Vesicular Monoamine Transporter
 (VMAT) 2 Inhibitors - continued**
 (PLEASE PRINT – ACCURACY IS IMPORTANT)

Chorea associated with Huntington’s disease (Austedo or tetrabenazine)

1. Patient meets the FDA approve age; and
2. Patient has a diagnosis of Huntington’s disease with chorea symptoms; and
3. Prescribed by or in consultation with a neurologist or psychiatrist; and
4. Is prescribed within the FDA approved dosing; and
5. Patient is not suicidal, or does not have untreated or inadequately treated depression; and
6. Patient does not have hepatic impairment; and
7. Patient does not have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and
8. For tetrabenazine, patients requiring doses above 50mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer; and
9. In patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed the following:
 - a. Austedo – 36mg per day (18mg single dose) or
 - b. Tetrabenazine – 50mg per day (25mg single dose)

If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met:

1. Patient continues to meet the criteria for initial approval; and
2. Documentation of improvement in chorea symptoms is provided.

Preferred

- Austedo Ingrezza Tetrabenazine

Non-Preferred

- Xenazine

Strength

Dosing Instructions

Quantity

Days’ Supply

Tardive Dyskinesia (Austedo or Ingrezza):

- Patient has ALL of the following:
 - Involuntary athetoid or choreiform movement
 - Documentation of a dopamine receptor blocking agent:
 Drug name & dose: _____ Trial dates: _____
 - Symptoms lasting longer than 4-8 weeks; date of onset: _____
- Is prescriber a: neurologist psychiatrist other: _____
 If other, note consultation date with a neurologist or psychiatrist: _____
 Physician name, phone & specialty: _____
- Has prescriber evaluated the patient’s current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD? Yes No
- Baseline AIMS score (attach results): _____ Date conducted: _____
- For Ingrezza: (Rev 1/20)
 Does patient have concurrent therapy with MAO inhibitors, strong CYP3A4 inducers, or other VMAT2 inhibitors? Yes No

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- For Austedo:
 - Is patient suicidal or have untreated or inadequately treated depression? Yes No
 - Does patient have hepatic impairment? Yes No
 - Does patient have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors?
 Yes No
 - Is patient taking a strong CYP2D6 inhibitor? Yes No
 - Has patient been identified as a poor CYP2D6 metabolizer? Yes No

Renewal Requests:

Updated AIMS score from baseline (attach results): _____ Date conducted: _____

Chorea associated with Huntington’s disease (Austedo or Tetrabenazine):

- Is prescriber a: neurologist psychiatrist other: _____
 If other, note consultation date with a neurologist or psychiatrist: _____
 Physician name, phone & specialty: _____
- Is patient suicidal or have untreated or inadequately treated depression? Yes No
- Does patient have hepatic impairment? Yes No
- Does patient have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors?
 Yes No
- Is patient taking a strong CYP2D6 inhibitor? Yes No
- Has patient been identified as a poor CYP2D6 metabolizer? Yes No
- For tetrabenazine doses above 50mg per day, has patient been tested and genotyped for the drug
 metabolizing enzyme CYP2D6 to determine if they are a poor or extensive metabolizer?
 Yes No

Renewal Requests:

Document improvement in chorea symptoms: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member’s Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.