FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization Vesicular Monoamine Transporter (VMAT) 2 Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered under the following conditions:

<u>Tardive Dyskinesia</u> (Ingrezza or Austedo)

1. **Patient meets the FDA approved age; and**
2. **Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following:**
   a. **Involuntary athetoid or choreiform movements**
   b. **Documentation or claims history of current or prior chronic use (≥ 3 months or 1 month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)**
   c. **Symptoms lasting longer than 4-8 weeks; and**
3. **Prescribed by or in consultation with a neurologist or psychiatrist; and**
4. **Prescriber has evaluated the patient's current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD; and**
5. **Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS); and**
6. **For Ingrezza:**
   a. **Will not be used concurrently with MAO inhibitors (e.g., isocarboxazid, phenelzine, rasagiline, safinamide, selegiline, tranylcypromine, etc.) or strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, phenobarbital, rifampin and related agents, St. John's wort, etc.); and**
   b. **Will not be used concurrently with other VMAT2 inhibitors; and**
   c. **Is prescribed within the FDA approved dosing; or**
7. **For Austedo:**
   a. **Patient does not have hepatic impairment; and**
   b. **Will not be used concurrently with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and**
   c. **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 36mg per day (18mg twice daily); and**
   d. **Is prescribed within the FDA approved dosing.**

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 TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS).**

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(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:
  Does patient have concurrent therapy with MAO inhibitors, strong CYP3A4 inducers, or other VMAT2 inhibitors? ☐ Yes ☐ No

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- For Austedo:
  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

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.*