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 (PA) 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 when the patient has an FDA approved or compendia indication for the requested drug under the following conditions:

1. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Will not be used concurrently with other vesicular monoamine transporter (VMAT) 2 inhibitors; and**
3. **Prescribed by or in consultation with a neurologist, psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and**

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

1. **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**
2. **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**
3. **Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS).**

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).**

<u>Chorea associated with Huntington's disease</u> (Austedo, Austedo XR, Ingrezza or tetrabenazine)

1. **Patient has a diagnosis of Huntington's disease with chorea symptoms; and**
2. **Patient is not suicidal, or does not have untreated or inadequately treated depression; and**
3. **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.**

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.**

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Vesicular Monoamine Transporter (VMAT) 2 Inhibitors

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Preferred

☐ Austedo ☐ Austedo XR ☐ Ingrezza ☐ Tetrabenazine

Non-Preferred

☐ Xenazine

Strength	Dosing Instructions	Quantity	Days' Supply
_____	_____	_____	_____

Prescriber Specialty: ❑ Neurologist ❑ Psychiatrist ❑ Psychiatric nurse practitioner ❑ Psychiatric physician assistant

❑ Other (specify consultation with a specialty provider):

Consultation Date:_____

Physician Name, Phone & Specialty: _____

Does patient have concurrent therapy with other VMAT2 inhibitors? ☐ Yes ☐ No

☐ **Tardive Dyskinesia** (Austedo, Austedo XR 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:_____
- 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:_____

Renewal Requests:

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

☐ **Chorea associated with Huntington's disease** (Austedo, Austedo XR, Ingrezza or Tetrabenazine):

- Is patient suicidal or have untreated or inadequately treated depression? ☐ 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 Health and Human Services, that the member continues to be eligible for Medicaid.*