Montana Healthcare Programs Prior Authorization Request Form for Use of Austedo® (deutetrabenazine)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>Prescriber Phone:</td>
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<tr>
<td>Prescriber Name/Specialty if Applicable:</td>
<td>Prescriber Fax:</td>
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<td>Dosage Requested:</td>
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Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

Please check appropriate diagnosis and complete corresponding information:

**Huntington’s Chorea**

☐ **INITIATION OF THERAPY**

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has functional disability resulting from chorea associated with Huntington’s disease, confirmed by a neurologist: ☐ Yes ☐ No
3. Is member at a significant risk for suicidal behavior? ☐ Yes ☐ No*

*Patients with Huntington’s disease are at increased risk for depression and suicidal ideation or behaviors (suicidality). Austedo may increase the risk for suicidality in patients with Huntington’s disease.

4. Member will be counseled on and monitored for depression and suicidal thoughts and behaviors: ☐ Yes ☐ No
5. Is member at risk for congenital long QT syndrome/arrhythmias associated with a prolonged QT interval? ☐ Yes ☐ No
6. Is member on any other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ Yes ☐ No
7. Is member concomitantly on a MAOI or reserpine? ☐ Yes ☐ No

**LIMITATIONS:**
Authorization will be granted for a maximum of 48mg/day.  

**Initial authorization will be issued for 12 weeks.**

☐ **CONTINUATION OF THERAPY**

Member has shown symptom improvement as evidenced by a decrease in the Total Maximal Chorea Score AND member is not at a significant risk for suicidal behavior.

**Reauthorization will be issued for 6 months.**
Tardive Dyskinesia

☐ INITIATION OF THERAPY

1. Last 6 months of chart notes are attached (required): □ Yes   □ No
2. Member is 18 years of age or older: □ Yes   □ No
3. Medication is prescribed by or in consult with (physically seen by): □ Psychiatrist   □ Neurologist
   □ Psychiatric mental health nurs practitioner (PMHNP)
4. Member has a diagnosis of moderate to severe tardive dyskinesia (TD): □ Yes   □ No
5. TD must be antipsychotic (dopamine receptor blocker) induced: □ Yes   □ No
6. Provider attests they have ruled out other potential causes of movement disorder, including but not
limited to stimulants, stimulant use disorder, metoclopramide, etc.: □ Yes   □ No
7. Symptoms have been present for at least 2 months prior to prescribing: □ Yes   □ No
8. Provide documented baseline evaluation of the condition using the Abnormal Involuntary Movement
Scale (AIMS) with a minimum score of \( >6 \) using items 1-7 (categories I, II, III).
   AIMS score (attach): _________
9. Member’s TD interferes with the patient’s functional status, including self-care and ambulation or
quality of life or creates a social stigma sufficient to cause social isolation or embarrassment:
   □ Yes   □ No
10. Prescriber has documented the specific movement(s) in the patient’s medical record along with how TD
is affecting the patient’s function, quality of life or socialization: □ Yes   □ No
11. Member has had an inadequate response to the following treatment modalities, unless all are
contraindicated, not tolerated or are inappropriate to maintain stable psychiatric function: □ Yes   □ No
   a. Discontinuation or dose modification of the offending medication
   b. Switching from a first-generation antipsychotic to a second-generation antipsychotic
12. Is member at risk for congenital long QT syndrome/arrhythmias associated with a prolonged QT
interval? □ Yes   □ No
13. Is member on any other vesicular monoamine transporter 2 (VMAT2) inhibitors? □ Yes   □ No
14. Is member concomitantly on a monoamine oxidase inhibitor (MAOI) or reserpine? □ Yes   □ No

LIMITATIONS:
Authorization will be granted for a maximum of 48mg/day.

Initial authorization will be issued for 12 weeks.

☐ CONTINUATION OF THERAPY

TD symptoms have improved as evidenced by improved AIMS score AND increased function, quality of life or
socialization (chart notes must be attached documenting improvement).

Reauthorization will be issued for 6 months.

Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350.