Mountain Pacific
INNOVATING BETTER HEALTH
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# Montana Healthcare Programs Prior Authorization Request Form for Use of Austedo® (deutetrabenazine) Austedo® XR (deutetrabenazine)

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|---|---|---|
| Member Name: | DOB: | Date: |
| Member ID: | Prescriber Phone: | |
| Prescriber Name/Specialty if Applicable: | Prescriber Fax: | |
| Dosage Requested: | | |

**Please complete below information for applicable situation, Initiation or Continuation of therapy:**

Please check appropriate diagnosis and complete corresponding information:

☐ **INITIATION OF THERAPY**

**Huntington's Chorea**

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. Provider attests they are aware of boxed warning of increased risk of depression and suicidal ideation and behavior in patients with Huntington's Disease: ☐ Yes ☐ No
4. Provider attests member is not at significant risk of suicidal behavior: ☐ Yes ☐ No
5. Provider attests member will be counseled on and monitored for depression and suicidal thoughts and behaviors: ☐ Yes ☐ No
6. Provider attests member will not concomitantly be on a monoamine oxidase inhibitor (MAOI) or reserpine: ☐ Yes ☐ No
7. Provider attests member will not use Austedo® or Austedo XR® concomitantly with any other vesicular monoamine transporter 2 (VMAT2) inhibitors: ☐ Yes ☐ No
8. If medication is nonpreferred (please refer to the Montana Medicaid Preferred Drug List for current preferred options), member has had an inadequate response, contraindication or intolerance to a **preferred** therapeutic alternative: ☐ Yes ☐ No ☐ N/A – drug is preferred.

   Drug name: _____ Date used: _____

   Reason for discontinuation: _____

**LIMITATIONS:**
Maximum daily dose: 48mg per day

**Initial authorization will be issued for 6 months.**

**Tardive Dyskinesia**

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of moderate to severe tardive dyskinesia (TD): ☐ Yes ☐ No
3. Medication is prescribed by or in consult with (physically seen by): ☐ Psychiatrist ☐ Neurologist ☐ Psychiatric NP (PMHNP)
4. Symptoms have been present for at least 2 months prior to prescribing: ☐ Yes ☐ No
5. Last 6 months of chart notes are attached (required): ☐ Yes ☐ No
6. TD must be antipsychotic (dopamine receptor blocker) induced: ☐ Yes ☐ No
7. 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
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; quality of life; or creates a social stigma sufficient to cause social isolation or embarrassment: ☐ Yes ☐ No
10. Prescriber has documented 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:
    - ☐ Discontinuation or dose modification of the offending medication
    - ☐ Switching from a first-generation antipsychotic to a second-generation antipsychotic
12. Provider attests member will not use Austedo®/Austedo XR® concomitantly with any other vesicular monoamine transporter 2 (VMAT2) inhibitors: ☐ Yes ☐ No
13. Provider attests member will not use Austedo®/Austedo XR® concomitantly with any other vesicular monoamine transporter 2 (VMAT2) inhibitors: ☐ Yes ☐ No
14. If medication is nonpreferred (please refer to the Montana Medicaid Preferred Drug List for current preferred options), member has had an inadequate response, contraindication or intolerance to a **preferred** therapeutic alternative: ☐ Yes ☐ No ☐ N/A – Drug is preferred.

    Drug name: _____ Date used: _____

    Reason for discontinuation: _____

**LIMITATIONS:**
Maximum daily dose: 48mg per day

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

## ☐ CONTINUATION OF THERAPY

**Huntington's Chorea**

1. Member has shown symptom improvement as evidenced by a decrease in the Total Maximal Chorea Score: ☐ Yes ☐ No
2. Member is not at significant risk for suicidal behavior: ☐ Yes ☐ No

**Tardive Dyskinesia**

1. TD symptoms have improved, evidenced by improved AIMS score AND increased function, quality of life or socialization (**chart notes must be attached**): ☐ Yes ☐ No
2. Chart notes from the last 6 months are attached: ☐ Yes ☐ No

**LIMITATIONS:**
Maximum daily dose: 48mg per day

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

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

10/2023