AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (select **ONE** below)

❑ **Austedo®** (deutetrabenazine)	❑ **Austedo® XR** (deutetrabenazine)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **DIAGNOSIS: Huntington's Disease**

Initial Authorization – 12 months. Dose may not exceed 48 mg/day.

- ❑ Prescribed by or in consultation with a Neurologist
- ❑ Member is ≥ 18 years of age
- ❑ Member has been diagnosed with chorea associated with Huntington's Disease
- ❑ Member has a trial and failure of **at least 30 days** of therapy with tetrabenazine **(verified by chart notes or pharmacy paid claims)**

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- ❑ Member is **NOT** actively suicidal and does **NOT** have any of the following:
  - ❑ untreated or inadequately treated depression
  - ❑ concomitant use of MAOI medication
  - ❑ hepatic impairment
- ❑ Member is **NOT** using concomitant therapy with tetrabenazine

Reauthorization – 12 months. Dose may not exceed 48 mg/day. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Chorea symptoms must have improved or stabilized
- ❑ Member is **NOT** actively suicidal and does **NOT** have any of the following:
  - ❑ untreated or inadequately treated depression
  - ❑ concomitant use of MAOI medication
  - ❑ hepatic impairment

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **DIAGNOSIS: Tardive Dyskinesia**

Initial Authorization – 6 months. Dose may not exceed 48 mg/day.

- ❑ Prescriber is one of the following **(check box below that applies)**:

❑ Neurologist	❑ Psychiatrist

- ❑ Member is ≥ 18 years of age
- ❑ Member has a diagnosis of moderate to severe tardive dyskinesia, meeting all DSM-5 diagnostic criteria **(chart notes must be attached)**
- ❑ Member has experienced involuntary athetoid or choreiform movements
- ❑ Member has a history of treatment with dopamine receptor blocking agent (DRBA) **(Claims history or chart notes must be attached)**
- ❑ Member's symptom duration has lasted more than 4 to 8 weeks
- ❑ Provider has submitted documentation that an AIMS test has been completed to obtain baseline evaluation **(testing or score must be attached)**

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- ❑ **ONE** of the following criteria exists:
  - ❑ Persistence symptoms of tardive dyskinesia despite a trial dose reduction, tapering, or discontinuation of the offending agent
  - ❑ Member is **NOT** a candidate for a trial dose reduction, tapering, or discontinuation of the offending agent
- ❑ Member is **NOT** actively suicidal and does **NOT** have any of the following:
  - ❑ untreated or inadequately treated depression
  - ❑ concomitant use of MAOI medication
  - ❑ hepatic impairment

Reauthorization - 12 months. Dose may not exceed 48 mg/day. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has experienced a positive clinical response to therapy **(chart notes must be attached)**
- ❑ Provider has noted an improvement in current AIMS score compared to baseline submission **(testing or score must be attached)**
- ❑ Member is **NOT** actively suicidal and does **NOT** have any of the following:
  - ❑ untreated or inadequately treated depression
  - ❑ concomitant use of MAOI medication
  - ❑ hepatic impairment

Medication being provided by a Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*