PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Austedo® (deutetrabenazine)

Member

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ____________ Gender: ____________

Primary Care Physician: ______________________

Requesting Provider: ______________________ Prov. Phone: ____________ Prov. Fax: ____________

Provider Address: ______________________

Provider NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ____________

Product Information

☐ New request ☐ Continuation request

Drug product:

☐ Austedo 6 mg tablet
☐ Austedo 9 mg tablet
☐ Austedo 12 mg tablet

Start date (or date of next dose): ____________

Date of last dose (if applicable): ____________

Dosing frequency: ____________

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements (must be 18 years of age or older):

1. Diagnosis of chorea associated with Huntington's disease.
2. Cannot be used in combination with tetrabenazine.

   Initial approval is 6 months. For continuation, patient must have met the following requirements (indefinite approval if meets continuation criteria after initial 6 months of use):

   1. Medical documentation submitted confirming:
      a. chorea symptoms have improved or stabilized, and
      b. that patient is being monitored for symptoms of depression and if depression is present, it is being addressed.

OR

1. Diagnosis of moderate to severe tardive dyskinesia (TD).
2. Documentation of the member's current Abnormal Involuntary Movement Scale (AIMS) score (available on this form) with a minimum score of 3 on item 8 (severity of abnormal movements overall).
3. Have tried and failed the following:
   a. Discontinuation of offending agent(s)
   b. Ingrezza (up to 80mg daily).

   Initial approval is 2 months. For continuation, patient must have met the following requirements (indefinite approval if meets continuation criteria after initial 2 months of use):

   1. Documentation of a decreased AIMS score (items 1 to 7) from baseline must be submitted to Priority Health.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 12/2017
Last reviewed 01/2019

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Chorea associated with Huntington's disease
- ☐ Tardive Dyskinesia (antipsychotic, dopamine receptor blocker, or metoclopramide-induced)
- ☐ *Other – the patient's condition is:* ____________________

Rationale for use: ____________________

B. Will the patient be using in combination with tetrabenazine?

- ☐ Yes, *rationale:* ____________________
- ☐ No

C. Does the patient have moderate or severe TD, which is indicated by a score of 3 or 4 on item 8 (severity of abnormal movements overall) of the Abnormal Involuntary Movement Scale (AIMS).

- ☐ Yes
- ☐ No; rationale:____________________

D. What is the patient's current AIMS score for items 1-7?_______________ (documentation must be submitted to Priority Health)

E. Is the member suicidal, have violent behaviors, or other unstable psychiatric symptoms?

- ☐ No
- ☐ Yes; rationale:____________________

F. What non-pharmacologic interventions has the patient tried?

____

____

____

____

G. Has the patient tried Ingrezza 80mg daily?

- ☐ Yes
- ☐ No; rationale:____________________

Request to continue a previously authorized approval
Priority Health Recertification Documentation

A. What condition is this drug being requested for?

- ☐ Chorea associated with Huntington's disease
- ☐ Tardive Dyskinesia (antipsychotic, dopamine receptor blocker, or metoclopramide-induced)
- ☐ *Other – the patient's condition is:* ____________________

Rationale for use: ____________________

B. Select which of the following apply (medical documentation must be submitted with request):

- ☐ Chorea symptoms have improved or stabilized
- ☐ Patient is being monitored for symptoms of depression
- ☐ The patient's AIMS score for items 1-7 decreased
  - ☐ No
  - ☐ Yes

New AIMS score: ____________________

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 12/2017
Last reviewed 01/2019

PriorityHealth

Abnormal involuntary movement scale

Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration
National Institute of Mental Health

KEY: 0 = None 1 = Minimal, may be extreme normal 2 = Mild 3 = Moderate 4 = Severe	NAME: ____________________ DATE: ____________ Prescribing practitioner: ____________________	
MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. Circle movement as well as code number that applies.		**RATER** **Date**
Facial and oral movements	1. **Muscles of facial expression** eg, movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	0 1 2 3 4
	2. **Lips and perioral area** eg, puckering, pouting, smacking	0 1 2 3 4
	3. **Jaw** eg, biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4
	4. **Tongue** Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth.	0 1 2 3 4
Extremity movements	5. **Upper (arms, wrists, hands, fingers)** Include choreic movements (ie, rapid, objectively purposeless, irregular, spontaneous) athetoid movements (ie, slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (ie, repetitive, regular, rhythmic).	0 1 2 3 4
	6. **Lower (legs, knees, ankles, toes)** eg, lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4
Trunk movements	7. **Neck, shoulders, hips** eg, rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4
Global judgments	8. **Severity** of abnormal movements overall	0 1 2 3 4
	9. **Incapacitation due to abnormal movements**	0 1 2 3 4
	10. **Patient's awareness of abnormal movements** Rate only patient's report - No awareness 0 - Aware, no distress 1 - Aware, mild distress 2 - Aware, moderate distress 3 - Aware, severe distress 4	0 1 2 3 4
Dental status	11. **Current problems with teeth and/or dentures?**	No Yes
	12. **Are dentures usually worn?**	No Yes
	13. **Edentia?**	No Yes
	14. **Do movements disappear in sleep?**	No Yes

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