

# US Family Health Plan

## Prior Authorization Request Form for deutetrabenazine (**Austedo**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

Initial prior authorization expires after 1 year, renewal criteria is approved indefinite. For renewal of therapy an initial TRICARE/US Family Health Plan prior authorization approval is required.

**Step 1 Please complete patient and physician information** (please print):

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

**Step 2 Please complete the clinical assessment:**

<b>2</b>	1. Does the patient have congenital or acquired long QT syndrome or arrhythmias associated with QT prolongation?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 2
	2. Does the patient have severe hepatic impairment?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 3
	3. Is the patient currently taking any of the following: MAOIs within the last 14 days, CYP3A4 inducers, reserpine, or another VMAT2 inhibitor (for example: tetrabenazine, valbenzaine or Ingrezza)?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 4
	4. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for Austedo	<input type="checkbox"/> Yes (subject to verification) Proceed to question 15	<input type="checkbox"/> No Proceed to question 5
	5. Does the patient have depression?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 7
	6. Is the patient being adequately treated for depression?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
	7. Does the patient have suicidal ideation?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 8

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<b>8. For which indication is the requested medication being prescribed?</b>	<input type="checkbox"/> Huntington's Disease Chorea - Proceed to question <b>13</b> <input type="checkbox"/> Tardive Dyskinesia with schizophrenia, schizoaffective disorder, or a mood disorder - Proceed to question <b>9</b> <input type="checkbox"/> Other - <b>STOP - Coverage not approved</b>	
<b>9. Is the requested medication being prescribed by or in consultation with a neurologist or psychiatrist?</b>	<input type="checkbox"/> Yes Proceed to question <b>10</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>10. Is the patient 18 years of age or older?</b>	<input type="checkbox"/> Yes Proceed to question <b>11</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>11. Is the tardive dyskinesia moderate to severe causing functional impairment?</b>	<input type="checkbox"/> Yes Proceed to question <b>12</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>12. Has the provider considered a dose reduction, tapering, or discontinuation of the dopamine receptor blocking agent suspected of causing the symptoms?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>13. Is the requested medication being prescribed by or in consultation with a neurologist?</b>	<input type="checkbox"/> Yes Proceed to question <b>14</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>14. Has the patient had an adequate trial of tetrabenazine for 12 weeks and experienced treatment failure OR experienced an adverse event that is not expected to occur with Austedo?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>15. Is the patient being monitored for depression and suicidal ideation?</b>	<input type="checkbox"/> Yes Proceed to question <b>16</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>16. For which indication is the requested medication being prescribed?</b>	<input type="checkbox"/> Huntington's Disease Chorea - Proceed to question <b>17</b> <input type="checkbox"/> Tardive Dyskinesia with schizophrenia, schizoaffective disorder, or a mood disorder - Proceed to question <b>18</b> <input type="checkbox"/> Other - <b>STOP - Coverage not approved</b>	
<b>17. Has the patient demonstrated improvement in symptoms based on clinical assessment?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>18. Has the patient demonstrated improvement in symptoms based on an improvement of at least 2 on the Abnormal Involuntary Movement Scale (AIMS)?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

I certify the above is true to the best of my knowledge. Please sign and date:

Step  
**3**

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date