STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

DEUTETRABENAZINE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
DEUTETRABENAZINE	AUSTEDO, AUSTEDO XR	44192		GPI-10 (6238003000)	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of chorea (involuntary movements) associated with Huntington's disease and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - Therapy is prescribed by or in consultation with a neurologist or movement disorder specialist

   If yes, **approve for 12 months by GPID or GPI-14 for ALL of the following:**
   - **6-12-24mg XR titration kit: #42 per 28 days for 1 fill.**
   - **6mg: #2 per day.**
   - **9mg: #4 per day.**
   - **12mg: #4 per day.**
   - **6mg XR: #7 per day.**
   - **12mg XR: #3 per day.**
   - **24mg XR: #2 per day.**

   If no, continue to #2.

2. Does the patient have a diagnosis of moderate to severe tardive dyskinesia (TD) and meet ALL of the following criteria?
   - The patient is 18 years of age or older
   - The patient's TD has been present for at least 3 months
   - Therapy is prescribed by or in consultation with a neurologist, movement disorder specialist, or psychiatrist
   - The patient has a prior history of using antipsychotic medications (e.g., aripiprazole, haloperidol, ziprasidone) or metoclopramide for at least 3 months (or at least 1 month if patient is 60 years of age or older) as documented in the prescription claims history

   If yes, **approve for 12 months by GPID or GPI-14 for ALL of the following:**
   - **6-12-24mg XR titration kit: #42 per 28 days for 1 fill.**
   - **6mg: #2 per day.**
   - **9mg: #4 per day.**
   - **12mg: #4 per day.**
   - **6mg XR: #7 per day.**
   - **12mg XR: #3 per day.**
   - **24mg XR: #2 per day.**

   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

CONTINUED ON NEXT PAGE

DEUTETRABENAZINE

GUIDELINES FOR USE (CONTINUED)

DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **DEUTETRABENAZINE (Austedo)** requires the following rule(s) be met for approval:

A. You have ONE of the following diagnoses:
   1. Chorea (involuntary muscle movements) associated with Huntington's disease
   2. Moderate to severe tardive dyskinesia (uncontrolled body movements)

B. You are 18 years of age or older

C. **If you have chorea associated with Huntington's disease, approval also requires:**
   1. Therapy is prescribed by or in consultation with a neurologist (type of brain doctor) or movement disorder specialist

D. **If you have moderate to severe tardive dyskinesia, approval also requires:**
   1. Moderate to severe tardive dyskinesia (uncontrolled body movements) has been present for at least 3 months
   2. Therapy is prescribed by or in consultation with a neurologist (type of brain doctor), movement disorder specialist, or psychiatrist (type of mental health doctor)
   3. You have a prior history of using antipsychotic medications (such as aripiprazole, haloperidol, ziprasidone) or metoclopramide for at least 3 months (or at least 1 month if you are 60 years of age or older) as documented in your prescription claims history

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Austedo, Austedo XR.

REFERENCES

- Austedo, Austedo XR [Prescribing Information]. Parsippany, NJ: Teva Neuroscience, Inc.; February 2023.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 08/21/23
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P&T Approval: 01/22