STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Services
Prior Authorization Criteria
Austedo® (deutetrabenazine)
Effective 4/1/2022

Prior Authorization Request Form

Austedo (Deutetrabenazine) *is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with chorea associated with Huntington's disease and for the treatment of tardive dyskinesia in adults.*

Initial* Prior Authorization Criteria:

- The patient must be within the age range as recommended by the FDA label; **AND**
- Patient must not be taking an MAOI (at least 14-days post-therapy), reserpine (must be >20 days post therapy) or any other concurrent VMAT2 inhibitor; **AND**
- Prescriber must provide a brief description of the medical necessity of therapy by documenting all target symptoms and their impact on the patient's function and activities of daily living; **AND**

The following indication-specific criteria also apply:

I. Treatment of Chorea associated with Huntington's Disease:

1. Request must come from the treating neurologist; **AND**
2. Patient must have been evaluated and found not to be suicidal or have untreated/undertreated depression; **AND**
3. All previous therapies must be documented along with their relative benefit. Unless contraindicated, the patient must have a documented 90-day trial, which resulted in intolerance or inadequate treatment response, to **Xenazine (tetrabenazine)**.

II. Treatment of Tardive Dyskinesia (TD):

1. Request must come from the treating neurologist or psychiatrist; **AND**
2. Patient must provide a documented clinical diagnosis of tardive dyskinesia meeting DSM-V criteria including:
    a. Involuntary athetoid or choreiform movements
    b. History of treatment with a dopamine receptor blocking agent (DRBA) such as an antipsychotic or metoclopramide
    c. Symptom duration lasting at least 8 weeks

AND

3. Prescriber must submit the results of an Abnormal Involuntary Movement Scale (AIMS) exam with every request for prior authorization of Austedo; **AND**

4. Prescriber must submit documentation of all other therapies attempted and their associated benefit **(including relevant AIMS scores)**.

***Initial prior-authorization will be for 90 days.**
Continuation of coverage requires clinically significant improvement in symptoms as compared to that seen using previous therapy.

References:

1.) Lexi-Comp drug monograph for Austedo (Reviewed 9/11/2018, 2/2022)
2.) Package insert for Austedo (last update 8/2017)
3.) Package insert for Xenazine (last update 9/2017)
4.) Abnormal Involuntary Movement Scale (AIMS) and Extrapyramidal Symptom Rating Scale (ESRS): cross-scale comparison in assessing tardive dyskinesia. Schizophr Res. 2005 Sep 15;77(2-3):119-28. Gharabawi GM[1], Bossie CA, Lasser RA, Turkoz I, Rodriguez S, Chouinard G.
5.) UpToDate Tardive Dyskinesia: Prevention and Treatment. Article last updated July 24, 2017
6.) American Academy of Neurology Evidence-based guideline: Treatment of tardive syndromes. July 29, 2013.
7.) Treatment of Huntington's Disease. Neurotherapeutics. 2014 Jan; 11(1): 153–160.
8.) American Academy of Neurology Evidence-based guideline: Pharmacologic treatment of chorea in Huntington disease. August 7, 2012.
9.) UpToDate: Huntington Disease: Management. Article last updated March 8, 2022.