UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Austedo

Program	Prior Authorization
Medication	Austedo (deutetrabenazine)
Markets in Scope	Arizona, California, Colorado, Hawaii, Nevada, New Jersey, New York, New York EPP, Pennsylvania-CHIP, Rhode Island, South Carolina
Issue Date	10/2017
Pharmacy and Therapeutics Approval Date	11/2020
Effective Date	12/2020

1. Background:

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

2. Coverage Criteria:

A. <u>Tardive Dyskinesia</u>

1. **<u>Initial Authorization</u>**

   a. Diagnosis of moderate to severe tardive dyskinesia

   -AND-

   b. **<u>One</u>** of the following:

   (1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication

   -OR-

   (2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

   -AND-

c. Prescribed by or in consultation with one of the following:

- Neurologist
- Psychiatrist

-AND-

d. History of failure, contraindication, or intolerance to Ingrezza

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Documentation of positive clinical response to Austedo therapy

Authorization will be issued for 12 months.

B. Chorea associated with Huntington's disease

1. **Initial Authorization**

a. Diagnosis of chorea associated with Huntington's disease

-AND-

b. Prescribed by or in consultation with a neurologist

-AND-

c. History of failure, contraindication, or intolerance to tetrabenazine

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Documentation of positive clinical response to Austedo therapy

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

4. References:

1. Austedo [package insert]. Parsippany, NJ: Teva Pharmaceuticals USA, Inc. June 2020.
2. Bhidayasiri R, Jitkritsadakul O, et al. Updating the recommendations for treatment of tardive syndromes: A systematic review of new evidence and practical treatment algorithm. J Neurol Sci. 2018;389:67-75.
3. Suchowersky, O. Huntington disease: Management. Hurtig, H (Ed). UpToDate. Waltham, MA: UpToDate Inc. http://www.uptodate.com (Accessed on April 1, 2020).

Program	Prior Authorization –Austedo (deutetrabenazine)
Change Control	
Date	Change
10/2017	New program
2/2018	Added trial of Ingrezza for tardive dyskinesia and trial of tetrabenazine for chorea associated with Huntington's disease due to PDL changes effective 4/1/18.
2/2019	Annual review, updated background.
5/2020	Annual review. Updated references.
11/2020	Annual review. Updated references