UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2018 P 2138-2 |
| Program | Prior Authorization/Medical Necessity |
| Medication | Austedo® (deutetrabenazine) |
| P&T Approval Date | 11/2017, 11/2018 |
| Effective Date | 2/1/2019;<br>Oxford only: 2/1/2019 |

## 1. Background

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

## 2. Coverage Criteria[a]:

**A. Tardive Dyskinesia**

1. **Initial Authorization**

a. **Austedo** will be approved based on **all** of the following criteria:

(1) Diagnosis of moderate to severe tardive dyskinesia

**-AND-**

(2) **One** of the following:

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

**-OR-**

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

**-AND-**

(3) Prescribed by or in consultation with **one** of the following:

(a) Neurologist
(b) Psychiatrist

**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. **Austedo** will be approved based on **both** of the following criteria:

      (1) Diagnosis of chorea associated with Huntington's disease

      **-AND-**

      (2) Prescribed by or in consultation with **one** of the following:

         (a) Neurologist
         (b) Psychiatrist

   **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.**

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

**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 Prescribing Information. Teva Pharmaceuticals Inc. August 2017.
2. Armstrong MJ, Miyasaki JM. Evidence-based guideline: Pharmacologic treatment of chorea in Huntington disease: Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology. 2012 August.
3. Claassen DO, Carroll B, De Boer LM, et al. Indirect tolerability comparison of deutetrabenazine and tetrabenazine for Huntington disease. J Clin Mov Disord. 2017. 4:3.
4. Geschwind MD, Paras N. Deutetrabenazine for treatment of chorea in Huntington disease. JAMA. 316(1):33-34.
5. Huntington Study Group. Effect of deutetrabenazine on chorea among patients with Huntington disease. JAMA. 2016; 316(1):40-50

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| **Change Control** | |
| 11/2017 | New program |
| 11/2018 | Annual review. No changes to clinical coverage criteria. |