UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2018 P 1236-3 |
| Program | Prior Authorization/Notification |
| Medication | Austedo® (deutetrabenazine) |
| P&T Approval Date | 11/2017, 11/2018 |
| Effective Date | 2/1/2019;<br>Oxford only: N/A |

## 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 the following criterion:

      (1) Diagnosis of tardive dyskinesia

   **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 the following criterion:

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

   **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, Step Therapy, and/or Medical Necessity may be in place

**4. References:**

1. Austedo Prescribing Information. Teva Pharmaceuticals Inc. August 2017.

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| **Change Control** | |
| 11/2017 | New program |
| 2/2018 | Administrative change to correct effective date. |
| 11/2018 | Annual review. No changes to clinical coverage criteria. |