



UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2022 P 1236-6
Program	Prior Authorization/Notification
Medication	Austedo [®] (deutetrabenazine)
P&T Approval Date	11/2017, 11/2018, 11/2019, 11/2020, 2/2022
Effective Date	5/1/2022; 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 [package insert]. Parsippany, NJ: Teva Pharmaceuticals Inc.; June 2021.

Program	Prior Authorization/Notification - Austedo (deutetrabenazine)
Change Control	
11/2017	New program
2/2018	Administrative change to correct effective date.
11/2018	Annual review. No changes to clinical coverage criteria.
11/2019	Annual review. No changes to clinical coverage criteria. Updated reference.
11/2020	Annual review. Updated reference.
2/2022	Annual review with no change to clinical criteria. Reference updated.