Austedo (deutetrabenazine) is a preferred product and will only be considered for coverage under the pharmacy benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### CHOREA ASSOCIATED WITH HUNTINGTON’S DISEASE

**For initial authorization:**
1. Member must be at least 18 years and older and medication is prescribed by neurologist or psychiatrist or nurse practitioner within a psychiatric or neurologic practice; AND
2. Member must have diagnosis of Huntington’s disease with chorea symptoms; AND
3. Documented consultation on risks of suicidal ideation or behavior while on Austedo is submitted with member’s chart notes (Austedo is contraindicated in patients who are suicidal, and in patients with untreated or inadequately treated depression); AND
4. Member’s baseline Total Maximal Chorea Score (of the Unified Huntington’s Disease Rating Scale (UHDRS)) is submitted with chart notes.
5. **Dosage allowed:** Starting dose of 6 mg once daily with weekly titration by 6 mg per day up to maximum dosage of 48 mg (24 mg twice daily).

**If member meets all the requirements listed above, the medication will be approved for 3 months.**

**For reauthorization:**
1. Member must be in compliance with all other initial criteria; AND
2. Member must have documentation of improvement of Total Maximal Chorea Scores after week 12.

**If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.**

### TARDIVE DYSKINESIA (TD)

**For initial authorization:**
1. Member is 18 years of age and older and medication is prescribed by neurologist or psychiatrist or nurse practitioner within a psychiatric or neurologic practice; AND
2. Member has clinical diagnosis of Tardive Dyskinesia documented in chart notes; AND
3. Member must try and fail at least 2 other guideline recommended treatments first (e.g., clonazepam, ginkgo biloba); AND
4. Chart notes confirming that member does not have risk for suicidal or violent behavior and has stable psychiatric symptoms; AND
5. If member has a history of substance use disorder, chart notes confirming that member is in remission for at least 3 months must be provided; AND
6. Member’s The Abnormal Involuntary Movement Scale (AIMS) score is documented in chart notes; AND
7. Member does not have ANY of the following:
   a) History of hepatic impairment;
   b) History of renal impairment;
   c) Allergy, hypersensitivity, or intolerance to tetrabenazine.
8. Dosage allowed: Starting dose of 12 mg once daily with weekly titration by 6 mg per day up to maximum dosage of 48 mg (24 mg twice daily).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For reauthorization:
1. Member must be in compliance with all other initial criteria; AND
2. Member must have documentation of improvement of AIMS score.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Austedo (deutetrabenazine) not medically necessary for the treatment of the diseases that are not listed in this document.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/16/2017</td>
<td>New policy for Austedo created.</td>
</tr>
<tr>
<td>11/01/2017</td>
<td>New diagnosis of Tardive Dyskinesia was added.</td>
</tr>
<tr>
<td>02/08/2018</td>
<td>Criterion requirement of clinical diagnoses of Tardive Dyskinesia for at least 3 months was removed. Length of initial authorization increased to 3 months. Criterion on guidelines recommended treatment was revised. Substance use disorder remission length requirement changed. New provider’s specialty was added for both diagnosis.</td>
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</tbody>
</table>

References:

Effective date: 02/21/2018
Revised date: 02/08/2018