HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
VMAT-2 INHIBITORS
Austedo®, Ingrezza®, tetrabenazine

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Austedo® (deutetrabenazine), ☐ Ingrezza® (valbenazine), ☐ tetrabenazine

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
TARDIVE DYSKINESA			
1. Is the request made by, or in consultation with, a psychiatrist or neurologist?	☐	☐	
2. Does documentation contain an Abnormal Involuntary Movement Scale (AIMS)?	☐	☐	**Please provide documentation**
3. Does documentation contain a Clinical Global Impression of Severity (CGI-S)?	☐	☐	**Please provide documentation**
4. Is the member currently taking reserpine or a MAO-I?	☐	☐	
5. For Ingrezza®, has the member had a 3-month trial and failure of a benzodiazepine and tetrabenazine?	☐	☐	**Please provide documentation**
6. For Austedo®, has the member had a 3-month trial and failure of Ingrezza®?	☐	☐	**Please provide documentation**
CHOREA ASSOCIATED WITH HUNTINGTON'S DISEASE			
1. Is the request made by, or in consultation with, a neurologist?	☐	☐	
2. Does documentation include a diagnosis made by characteristic motor examination features and genetic testing?	☐	☐	**Please provide documentation**
3. Is the member ambulatory?	☐	☐	
4. Has the member tried and failed at least two of the following: amantadine, an antipsychotic, riluzole, nabilone?	☐	☐	**Please provide documentation**

5. For Austedo®, has the member had a 3-month trial and failure of tetrabenazine?	☐	☐	**Please provide documentation**
TOURETTE SYNDROME			
1. Have non-pharmacologic therapies been tried and found to be inadequate to meet treatment goals?	☐	☐	**Please provide documentation**
2. Has the member tried and failed at least 3 of the following medications: guanfacine, clonidine, topiramate, botulinum toxin, fluphenazine, haloperidol, risperidone, pimozide, aripiprazole?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Does clinical documentation show a continued medical need as well as medication efficacy defined as objective progress towards treatment plan goals?	☐	☐	**Please provide documentation**
2. If the request for reauthorization of therapy for tardive dyskinesia, does clinical documentation show a continued medical need as well as medication efficacy defined by the AIMS score has decreased by at least 2 points from based line and the CGI-S score is ≤ 2?	☐	☐	**Please provide documentation**
3. If the request is for reauthorization of therapy for Huntington's disease, does updated documentation show disease stabilization and functional improvement of symptoms?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM- 076
Origination Date: 03/21/2018
Reviewed/Revised Date: 05/18/2022
Next Review Date: 05/18/2023
Current Effective Date: 06/01/2022