



Request for Prior Authorization
Vesicular Monoamine Transporter
(VMAT) 2 Inhibitors

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered under the following conditions:

Tardive Dyskinesia (Ingrezza or Austedo)

- 1. Patient meets the FDA approved age; and
2. Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following:
a. Involuntary athetoid or choreiform movements
b. Documentation or claims history of current or prior chronic use (≥ 3 months or 1 month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)
c. Symptoms lasting longer than 4-8 weeks; and
3. Prescribed by or in consultation with a neurologist or psychiatrist; and
4. Prescriber has evaluated the patient's current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD; and
5. Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS); and
6. For Ingrezza:
a. Will not be used concurrently with MAO inhibitors (e.g., isocarboxazid, phenelzine, rasagiline, safinamide, selegiline, tranylcypromine, etc.) or strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, phenobarbital, rifampin and related agents, St. John's wort, etc.); and
b. Will not be used concurrently with other VMAT2 inhibitors; and
c. Is prescribed within the FDA approved dosing; or
7. For Austedo:
a. Patient is not suicidal, or does not have untreated/inadequately treated depression;
b. Patient does not have hepatic impairment;
c. Will not be used concurrently with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and
d. Patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed 36mg per day (18mg twice daily); and
e. Is prescribed within the FDA approved dosing.

If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met:

- 1. Patient continues to meet the criteria for initial approval; and
2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS).

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**Chorea associated with Huntington’s disease (Austedo or tetrabenazine)**

1. Patient meets the FDA approve age; and
2. Patient has a diagnosis of Huntington’s disease with chorea symptoms; and
3. Prescribed by or in consultation with a neurologist or psychiatrist; and
4. Is prescribed within the FDA approved dosing; and
5. Patient is not suicidal, or does not have untreated or inadequately treated depression; and
6. Patient does not have hepatic impairment; and
7. Patient does not have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and
8. For tetrabenazine, patients requiring doses above 50mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer; and
9. In patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed the following:
  - a. Austedo – 36mg per day (18mg single dose) or
  - b. Tetrabenazine – 50mg per day (25mg single dose)

If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met:

1. Patient continues to meet the criteria for initial approval; and
2. Documentation of improvement in chorea symptoms is provided.

**Preferred**

**Non-Preferred**

- Austedo     Tetrabenazine                       Ingrezza     Xenazine

**Strength**

**Dosing Instructions**

**Quantity**

**Days’ Supply**

\_\_\_\_\_

**Tardive Dyskinesia** (Austedo or Ingrezza):

- Patient has ALL of the following:
  - Involuntary athetoid or choreiform movement
  - Documentation of a dopamine receptor blocking agent:  
Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_
  - Symptoms lasting longer than 4-8 weeks; date of onset: \_\_\_\_\_
- Is prescriber a:  neurologist     psychiatrist     other: \_\_\_\_\_  
If other, note consultation date with a neurologist or psychiatrist: \_\_\_\_\_  
Physician name, phone & specialty: \_\_\_\_\_
- Has prescriber evaluated the patient’s current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD?     Yes     No
- Baseline AIMS score (attach results): \_\_\_\_\_ Date conducted: \_\_\_\_\_
- For Ingrezza:  
Does patient have concurrent therapy with MAO inhibitors, strong CYP3A4 inducers, or other VMAT2 inhibitors?     Yes     No

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• For Austedo:

Is patient suicidal or have untreated or inadequately treated depression?  Yes  No

Does patient have hepatic impairment?  Yes  No

Does patient have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors?  
 Yes  No

Is patient taking a strong CYP2D6 inhibitor?  Yes  No

Has patient been identified as a poor CYP2D6 metabolizer?  Yes  No

Renewal Requests:

Updated AIMS score from baseline (attach results): \_\_\_\_\_ Date conducted: \_\_\_\_\_

**Chorea associated with Huntington's disease** (Austedo or Tetrabenazine):

• Is prescriber a:  neurologist  psychiatrist  other: \_\_\_\_\_  
If other, note consultation date with a neurologist or psychiatrist: \_\_\_\_\_

Physician name, phone & specialty: \_\_\_\_\_

• Is patient suicidal or have untreated or inadequately treated depression?  Yes  No

• Does patient have hepatic impairment?  Yes  No

• Does patient have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors?  
 Yes  No

• Is patient taking a strong CYP2D6 inhibitor?  Yes  No

• Has patient been identified as a poor CYP2D6 metabolizer?  Yes  No

• For tetrabenazine doses above 50mg per day, has patient been tested and genotyped for the drug  
metabolizing enzyme CYP2D6 to determine if they are a poor or extensive metabolizer?  
 Yes  No

Renewal Requests:

Document improvement in chorea symptoms: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.