

## Pharmacy Prior Approval Request for Austedo

### Beneficiary Information

1. Beneficiary Last Name: _____	2. First Name: _____	
3. Beneficiary ID #: _____	4. Beneficiary Date of Birth: _____	5. Beneficiary Gender: _____

### Prescriber Information

7. Prescribing Provider NPI #: _____
8. Requester Contact Information Name: _____ Phone #: _____ Ext. _____

### Drug Information

9. Drug Name: _____	10. Strength: _____	11. Quantity per 30 days: _____				
12. Length of Therapy						
Initial Request (circle # days):	30	60	90	120	180	
Continuation Request (circle # days):	30	60	90	120	180	365

### Clinical Information

#### Tardive Dyskinesia

##### Initial Request

Does the beneficiary have a diagnosis of moderate to severe Tardive Dyskinesia? Yes <input type="checkbox"/> No <input type="checkbox"/>
1. Is the beneficiary 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the provider submitted documented baseline evaluations of the condition using either Abnormal Involuntary Movement Scale(AIMS) or Extrapyramidal Symptom Rating Scale (ESRI) along with this request? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the beneficiary received a previous trial of an alternative method to manage the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list method tried _____
4. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the beneficiary have a history of depression or suicidal ideation? <input type="checkbox"/> Yes <input type="checkbox"/> No 7a. If yes, is the beneficiary being treated and/or stable? <input type="checkbox"/> Yes <input type="checkbox"/> No

#### Continuation Request for Tardive Dyskinesia (must also answer questions 1-7a above)

1. Has the beneficiary met all the above criteria for Tardive Dyskinesia? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the provider submitted documentation with this request that indicates the beneficiary has had an improvement in their symptoms from baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No

#### Huntington's Disease Initial Request

1. Does the beneficiary have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the beneficiary 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the beneficiary have a history of depression or suicidal ideation? <input type="checkbox"/> Yes <input type="checkbox"/> No 5a. If yes, is the beneficiary being treated and/or stable? <input type="checkbox"/> Yes <input type="checkbox"/> No

#### Huntington's Disease Continuation Request (must also answer questions 1-5a above)

1. Has the beneficiary met all the above criteria for Huntington's Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the provider submitted documentation with this request that indicates the beneficiary has had an improvement in their symptoms from baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Prescriber Signature mandatory*

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.