carolina complete health

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

1. Does the member have a diagnosis of moderate to severe Tardive Dyskinesia? ☐Yes ☐No
2. Is the member18 years old or older? ☐Yes ☐No
3. 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? ☐Yes ☐No
   3a.Please include **AIMS score**: _____ or **ESRI score:** _____
   a.
4. Has the member received a previous trial of an alternative method to manage the condition? ☐Yes ☐No
   Please list method tried _____
5. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ Yes ☐No
6. Is the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐ Yes ☐ No
7. Does the beneficiary have a history of depression or suicidal ideation? ☐ Yes ☐ No
   7a. If yes, is the beneficiary being treated and/or stable? ☐ Yes ☐ No

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

1. Has the member met all the above criteria for Tardive Dyskinesia? ☐ Yes ☐No
2. Has the provider submitted documentation with this request that indicates the member has had an improvement in their symptoms from baseline? ☐ Yes ☐ No

Huntington's Disease Initial Request

1. Does the member have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea? ☐ Yes ☐ No
2. Is the member 18 years old or older? ☐Yes ☐ No
3. Is the member receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ Yes ☐No
4. Is the member concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐Yes ☐No
5. Does the member have a history of depression or suicidal ideation? ☐Yes ☐No

5a. If yes, is the member being treated and/or stable? ☐ Yes ☐ No

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

1. Has the member met all the above criteria for Huntington's Disease? ☐ Yes ☐ No
2. Has the provider submitted documentation with this request that indicates the member has had an improvement in their symptoms from baseline? ☐ Yes ☐ 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.