

Pharmacy Prior Approval Request for Austedo

3. Beneficiary ID #:	1.	Beneficiary Last Name:		_2. First N	ame:			
7. Prescribing Provider NPI#: 8. Requester Contact Information Name:	3.	Beneficiary ID #:	4. Beneficiary Date of Birth:			5. Beneficiary Gender:		
7. Prescribing Provider NPI#: 8. Requester Contact Information Name: Phone #:	resc	riber Information						
9. Drug Name:	8. F	Requester Contact Information					-	Ext
9. Drug Name:								
Initial Request (circle # days): 30 60 90 120 180 Continuation Request (circle # days): 30 60 90 120 180 365 Inical Information Indive 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: or ESRI score: a. 4. Has the member received a previous trial of an alternative method to manage the condition? Yes No No Please list method tried 5. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? Yes No 7. Does the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? Yes No No 7a. If yes, is the beneficiary being treated and/or stable? Yes No No No No No No No N			ath		11 Ouen	titu nor 20	dovo	
Initial Request (circle # days): 30 60 90 120 180 Continuation Request (circle # days): 30 60 90 120 180 365 Inical Information Indive Dyskinesia- Initial Request 1. Does the member have a diagnosis of moderate to severe Tardive Dyskinesia?			igin:		_ i i. Quan	illy per 30	days:	
Inical Information redive Dyskinesia- Initial Request 1. Does the member have a diagnosis of moderate to severe Tardive Dyskinesia?YesNo 2. Is the member lay years old or older?YesNo 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?YesNo 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?YesNo Please list method tried 5. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors?	12.	Length of Therapy						
inical Information Indive Dyskinesia- Initial Request 1. Does the member have a diagnosis of moderate to severe Tardive Dyskinesia?		Initial Request (circle # days): 30	60	90	120	180		
1. Does the member have a diagnosis of moderate to severe Tardive Dyskinesia?		Continuation Request (circle # days):	30	60	90	120	180	365
 Has the member met all the above criteria for Tardive Dyskinesia? ☐ Yes ☐ No Has the provider submitted documentation with this request that indicates the member has had an improvement in their symptoms from baseline? ☐ Yes ☐ No Does the member have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea? ☐ Yes ☐ No Is the member 18 years old or older? ☐ Yes ☐ No Is the member receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ Yes ☐ No Is the member concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐ Yes ☐ No 	3.4.5.6.	Has the provider submitted docume Movement Scale(AIMS) or Extrapy 3a.Please include AIMS scale. a. Has the member received a previous Please list method tried Is the beneficiary receiving dual the YesNo Is the beneficiary concurrently usin Does the beneficiary have a history	ented baseling ramidal Sympore: us trial of an erapy with other of depression of depression raming a monoamity of depression of	alternative ner vesicula ine oxidase on or suicid	method to ar monoam inhibitor (Nal ideation)	or ESRI s or ESRI s manage the sine transp MAOI) or r ? □ Yes	with this core: ne condition orter 2 (V eserpine?	on? □Yes □ No MAT2) inhibitors?
 Has the provider submitted documentation with this request that indicates the member has had an improvement in their symptoms from baseline? ☐ Yes ☐ No Intington's Disease Initial Request Does the member have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea? ☐ Yes ☐ No Is the member 18 years old or older? ☐ Yes ☐ No Is the member receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ Yes ☐ No Is the member concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐ Yes ☐ No 	ontin	uation Request for Tardive Dyskinesia	ı (must also a	nswer ques	stions 1-7a	above		
 Does the member have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea?		Has the provider submitted documentation with this request that indicates the member has had an improvement						
 Does the member have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea?	untir	ngton's Disease Initial Request						
 Is the member 18 years old or older? ☐ Yes ☐ No Is the member receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ Yes ☐ No Is the member concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐ Yes ☐ No 		Does the member have a diagnosis	s of Huntingto	on's Diseas	e and is ex	periencin	g signs ar	nd symptoms of
 ☐ Yes ☐ No 4. Is the member concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐ Yes ☐ No 		Is the member 18 years old or olde						
4. Is the member concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐Yes ☐No	3.		py with other	vesicular r	nonoamine	transport	er 2 (VMA	AT2) inhibitors?
o. Dood the member have a history of depression of saletain idealions. 🗀 tes 🗀 No		Is the member concurrently using a						□Yes □No

Fax this form to (833) 404-2393

Pharmacy PA Call Center: (833) 585-4309

Continued on next page

Huntington's Disease Continuation Request (must also answer questions 1-5a above)					
	Has the member met all the above criteria for Huntington's Disease? Yes No 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: _____

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.