



PRIOR AUTHORIZATION REQUEST

AUSTEDO

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for a continuation of therapy?	
	<input type="checkbox"/> Initial (If checked, go to 7)	
	<input type="checkbox"/> Continuation (If checked, go to 2)	
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes No

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? <input type="checkbox"/> Chorea associated with Huntington's disease (If checked, go to 8) <input type="checkbox"/> Tardive dyskinesia (If checked, go to 14) <input type="checkbox"/> Other (if checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has the patient tried at least ONE other agent for at least 3 months? [Note: Examples of other agents include tetrabenazine with dose optimization, amantadine, and riluzole.] [If yes, skip to question 11.]	Yes	No
10	Does the patient have a documented intolerance to at least TWO other agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of other agents include tetrabenazine with dose optimization, amantadine, and riluzole.] [If no, no further questions.]	Yes	No
11	Is the patient's diagnosis confirmed by genetic testing (for example, an expanded HTT CAG repeat sequence of at least 36)? [If no, no further questions.]	Yes	No
12	Is this medication being prescribed by, or in consultation with, a neurologist? [If no, no further questions.]	Yes	No
13	Does the dose of the requested medication exceed FDA approved label dosing for	Yes	No

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the indication?

[Note: 12mg-48mg daily.]

[No further questions.]

- | | | | |
|----|---|-----|----|
| 14 | Is the patient greater than or equal to 18 years of age?
[If no, no further questions.] | Yes | No |
| 15 | Has the patient tried at least ONE other agent for at least 3 months OR has a documented intolerance? ACTION REQUIRED: Submit supporting documentation.
[Note: Examples of other agents include tetrabenazine with dose optimization.]
[If no, no further questions.] | Yes | No |
| 16 | Does the patient have persistent symptoms of moderate or severe tardive dyskinesia indicated on the Abnormal Involuntary Movement Scale (AIMS)?
[If no, no further questions.] | Yes | No |
| 17 | Does the patient have any ONE of the following: A) Untreated psychiatric illness, B) Score of greater than or equal to 11 on the depression subscale of the Hospital Anxiety and Depression Scale (HADS), C) A history of suicidal thoughts or behavior, D) Hepatic impairment, E) Concurrent use of monoamine oxidase inhibitors, reserpine, tetrabenazine, or valbenazine?
[If yes, no further questions.] | Yes | No |
| 18 | Is this medication being prescribed by, or in consultation with, a neurologist or psychiatrist?
[If no, no further questions.] | Yes | No |
| 19 | Does the dose of the requested medication exceed FDA approved label dosing for the indication?
[Note: 12 mg-48 mg daily.] | Yes | No |

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

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FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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