TRICARE Prior Authorization Request Form for
deutetrabenazine (Austedo/Austedo XR)

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial prior authorization expires after 1 year, renewal criteria is approved indefinite. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. The provider acknowledges the FDA safety alerts, boxed warnings, precautions, and drug interactions.	☐ Acknowledged Proceed to question **2**	
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication..*	☐ Yes (subject to verification) Proceed to question **13**	☐ No Proceed to question **4**
4. Does the patient have depression?	☐ Yes Proceed to question **5**	☐ No Proceed to question **6**
5. Is the patient being adequately treated for depression?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have suicidal ideation?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**

Continue on next page

7. For which indication is the requested medication being prescribed? Note: Non-FDA-approved uses are NOT approved (for example, Tourette's, dystonia).	☐ Huntington's Disease Chorea - Proceed to question **11** ☐ Tardive Dyskinesia with schizophrenia, schizoaffective disorder, or a mood disorder - Proceed to question **8** ☐ Other - **STOP - Coverage not approved**	
8. Is the requested medication being prescribed by or in consultation with a neurologist or psychiatrist?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the tardive dyskinesia moderate to severe causing functional impairment?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the provider considered a dose reduction, tapering, or discontinuation of the dopamine receptor blocking agent suspected of causing the symptoms?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Has the patient had an adequate trial of tetrabenazine for 12 weeks and experienced treatment failure OR experienced an adverse event that is not expected to occur with the requested medication?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Is the patient being monitored for depression and suicidal ideation?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. For which indication is the requested medication being prescribed? Note: Non-FDA-approved uses are NOT approved (for example, Tourette's, dystonia).	☐ Huntington's Disease Chorea - Proceed to question **15** ☐ Tardive Dyskinesia with schizophrenia, schizoaffective disorder, or a mood disorder - Proceed to question **16** ☐ Other - **STOP - Coverage not approved**	
15. Has the patient demonstrated improvement in symptoms based on clinical assessment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
16. Has the patient demonstrated improvement in symptoms based on an improvement of at least 2 on the Abnormal Involuntary Movement Scale (AIMS)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[28 February 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: