



Prior Authorization
JOHNS HOPKINS HEALTHCARE (MEDICAID) Austedo - Priority Partners MCO
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at 1-410-424-4607 . Please contact Johns Hopkins Healthcare at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Austedo - Priority Partners MCO.

Drug Name (select from list of drugs shown) Austedo (deutetrabenazine)

Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
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NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 7.]

2. Does the patient have a diagnosis of tardive dyskinesia?	<input type="checkbox"/> Y <input type="checkbox"/> N
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NOTE: Documentation must be submitted.	
[If yes, skip to question 5.]	
3. Does the patient have a diagnosis of chorea associated with Huntington's disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Documentation must be submitted.	
[If no, no further questions.]	
4. Has the patient had a documented trial and failure of generic tetrabenazine?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Documentation must be submitted.	
[If no, no further questions.]	
5. Is the prescribed dose 48 milligrams per day or less?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
6. Does the patient have any of the following exclusions to therapy: A) concomitant use of tetrabenazine and Austedo, B) Patient has suicidal or has suicidal ideations, C) Patient has untreated or inadequately treated depression, D) Patient has impaired hepatic function, E) Patient is currently using a monoamine oxidase inhibitor, F) Patient is currently using reserpine or has used reserpine in the past 20 days, G) Patient is pediatric?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
7. Is there clinical documentation supporting continued benefit of the requested medication?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Documentation must be submitted.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date