JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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.

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. Does the patient have congenital or acquired long QT syndrome or arrhythmias associated with QT prolongation?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Does the patient have severe hepatic impairment?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Is the patient currently taking any of the following: MAOIs within the last 14 days, CYP3A4 inducers, reserpine, or another VMAT2 inhibitor (for example: tetrabenazine, valbenzaine or Ingrezza)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. 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 Austedo*	☐ Yes (subject to verification) Proceed to question **15**	☐ No Proceed to question 5
5. Does the patient have depression?	☐ Yes Proceed to question **6**	☐ No Proceed to question **7**
6. Is the patient being adequately treated for depression?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have suicidal ideation?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**

Continue on next page

8. For which indication is the requested medication being prescribed?	☐ Huntington's Disease Chorea - Proceed to question **13** ☐ Tardive Dyskinesia with schizophrenia, schizoaffective disorder, or a mood disorder - Proceed to question **9** ☐ Other - **STOP - Coverage not approved**	
9. Is the requested medication being prescribed by or in consultation with a neurologist or psychiatrist?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient 18 years of age or older?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the tardive dyskinesia moderate to severe causing functional impairment?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. 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**
13. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. 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 Austedo?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Is the patient being monitored for depression and suicidal ideation?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. For which indication is the requested medication being prescribed?	☐ Huntington's Disease Chorea - Proceed to question **17** ☐ Tardive Dyskinesia with schizophrenia, schizoaffective disorder, or a mood disorder - Proceed to question **18** ☐ Other - **STOP - Coverage not approved**	
17. Has the patient demonstrated improvement in symptoms based on clinical assessment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
18. 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

Prior Authorization Request Form for deutetrabenazine (Austedo)

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