UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Austedo

Program	Prior Authorization
Medication	Austedo (deutetrabenazine)
Markets in Scope	Arizona, California, Florida-CHIP, Hawaii, Maryland, Nevada, New Mexico, New York, New York EPP, Ohio, Rhode Island
Issue Date	10/2017
Pharmacy and Therapeutics Approval Date	2/2018
Effective Date	4/2018

1. Background:

Austedo is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of chorea associated with Huntington's disease. Austedo is also indicated for the treatment of tardive dyskinesia in adults.

2. Coverage Criteria:

A. <u>Tardive Dyskinesia</u>

1. **<u>Initial Authorization</u>**

   a. Diagnosis of moderate to severe tardive dyskinesia

   -AND-

   b. **<u>One</u>** of the following:

      (1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication

      -OR-

      (2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

   -AND-

   c. Prescribed by or in consultation with one of the following:

- Neurologist
- Psychiatrist

-AND-

d. History of failure, contraindication, or intolerance to Ingrezza

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Documentation of positive clinical response to Austedo therapy

Authorization will be issued for 12 months.

B. Chorea associated with Huntington's Disease

1. **Initial Authorization**

a. Diagnosis of chorea associated with Huntington's Disease

-AND-

b. Prescribed by or in consultation with a neurologist

-AND-

c. History of failure, contraindication, or intolerance to tetrabenazine

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Documentation of positive clinical response to Austedo therapy

Authorization will be issued for 12 months.

3. References:

1. Austedo Prescribing Information. Teva Pharmaceuticals Inc. August 2017.

2. Armstrong MJ, Miyasaki JM. Evidence-based guideline: Pharmacologic treatment of chorea in Huntington disease: Report of the Guideline Development Subcommittee of the American Academy of Neurology. August 2012.
3. Claassen DO, Carroll B, De Boer LM, et al. Indirect tolerability comparison of deutetrabenazine and tetrabenazine for Huntington disease. J Clin Mov Disord. 2017. 4:3.
4. Geschwind MD, Paras N. Deutetrabenazine for treatment of chorea in Huntington disease. JAMA. 316(1):33-34.
5. Huntington Study Group. Effect of deutetrabenazine on chorea among patients with Huntington disease. JAMA. 2016; 316(1):40-50.

Program	Prior Authorization –Austedo (deutetrabenazine)
Change Control	
Date	Change
10/2017	New program
2/2018	Added trial of Ingrezza for tardive dyskinesia and trial of tetrabenazine for chorea associated with Huntington's disease due to PDL changes effective 4/1/18.