GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

AUSTEDO (deutetrabenazine) PRIOR AUTHORIZATION FORM *(form effective 01/03/2022)*

Prior authorization guidelines for **VMAT2 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: ☐Austedo tablet ☐Austedo _____		Strength:
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx codes (*required*):	

ALL requests

Do any of the following contraindications apply to the beneficiary? *Check all that apply.* ☐Actively suicidal ☐Taken an MAO inhibitor in the past 14 days ☐Hepatic impairment ☐Taken reserpine in the past 20 days ☐Taking Xenazine or Ingrezza ☐Depression that is untreated or inadequately treated	☐Yes ☐No *Submit supporting documentation, including liver function test (LFT) results, mental health evaluation, and medication list.*
If the beneficiary is known to be a poor CYP2D6 metabolizer or will be taking a strong CYP2D6 inhibitor (such as bupropion, fluoxetine, paroxetine, or quinidine), will the dose of Austedo be adjusted accordingly?	☐Yes ☐No *Submit documentation of dosing and beneficiary's complete medication list.*
Is Austedo being prescribed by or in consultation with a neurologist or psychiatrist?	☐Yes ☐No *If prescriber is not a specialist, submit documentation of consultation.*

INITIAL requests

Does the beneficiary have one of the following diagnoses? ☐Chorea associated with Huntington's disease ☐Tardive dyskinesia	☐Yes – *Submit documentation supporting beneficiary's diagnosis.* ☐No – *Submit medical literature documentation supporting the use of Austedo for the beneficiary's diagnosis.*
Did the beneficiary have a mental health evaluation?	☐Yes ☐No *Submit documentation of evaluation.*
If the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder, was the beneficiary evaluated in the past 6 months and treated by a psychiatrist?	☐Yes ☐No *Submit documentation of evaluation and treatment.*
For the treatment of tardive dyskinesia, *submit documentation of the following* as it applies to the beneficiary*:* ☐Has no other causes of involuntary movement ☐A dose decrease of dopamine receptor blocking agents is not appropriate ☐Has documentation of TD severity	

RENEWAL requests

Since starting Austedo, did the beneficiary experience an improvement in the medical condition being treated?	☐Yes ☐No *Submit documentation of beneficiary's response to therapy.*
Was the beneficiary reevaluated (and treated, if applicable) for new onset or worsening symptoms of depression and determined to be a candidate for treatment with Austedo?	☐Yes ☐No *Submit documentation of evaluation.*

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

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Prescriber Signature:	**Date**: