TEXAS MEDICAID
Clinical Edit Prior Authorization
deutetrabenazine (AUSTEDO), tetrabenazine (XENAZINE)

Texas Children's Health Plan Only

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the request for tetrabenazine (XENAZINE) and the client has one (1) of the following diagnoses in the last 365 days?

   *These are off-label diagnoses that are covered only by Texas Children's Health Plan

   - Abnormal involuntary movements – R25.9
   - Chorea – G25.5
   - Dystonia – G24.9
   - Motor tic disorder – F95.8
   - Serotyped movements – F98.4
   - Tardive Dyskinesia – G24.01
   - Tourette Syndrome – F95.2

   ☐ Yes (Approve – 365 days) ☐ No (Go to #2)

2. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of Huntington-induced chorea in the last 365 days?

   ☐ Yes (Go to #4)
   ☐ No (And the request is for deutetrabenazine, go to #6)
   ☐ No (And the request is for tetrabenazine, deny)

4. Is the medication being prescribed by, or its use overseen by, a neurologist or a psychiatrist? [Manual Step]

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a diagnosis of severe depression or suicide attempt/ideation in the last 180 days?

   ☐ Yes (Deny) ☐ No (Go to #7)

6. Does the client have a diagnosis of tardive dyskinesia in the last 365 days?

   ☐ Yes (Go to #7) ☐ No (Deny)

7. Does the client have a diagnosis of hepatic impairment in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #8)

8. Does the client have one (1) claim for a monoamine oxidase (MAO) inhibitor in the last 90 days?

   Examples include AZILECT, linezolid (ZYVOX), MARPLAN, phenelzine (NARDIL), selegiline (EMSAM, ZELAPAR), and tranylcypromine (PARNATE).

   ☐ Yes (Deny) ☐ No (Go to #9)

9. Has the client had one (1) claim for a strong CYP2D6 inhibitor in the last 90 days?

   Examples includes bupropion (APLENZIN, FORFIVO, WELLBUTRIN, ZYBAN), fluoxetine (PROZAC), olanzapine-fluoxetine (SYMBYAX), paroxetine (BRISDELLE, PAXIL, PEXEVA), quinidine, and SENSIPAR.

   ☐ Yes (Go to #10) ☐ No (Approve - 365 days)

10. Is the daily dose less than or equal (≤) to 50 mg (tetrabenazine [XENAZINE]) or 36 mg (deutetrabenazine [AUSTEDO])?

    ☐ Yes (Approve - 365 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.