

## VMAT2 Inhibitors (Austedo, Xenazine) Prior Authorization of Benefits Form

Contains confidential patient information

Complete form in its entirety and fax to the Prior Authorization of Benefits Center at 1-844-474-3341.

### 1. Patient information

### 2. Physician information

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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### 3. Medication

### 4. Strength

### 5. Directions

### 6. Quantity per 30 days

<input type="checkbox"/> Austedo (deutetrabenazine) <input type="checkbox"/> Xenazine (tetrabenazine) <input type="checkbox"/> Ingrezza (Valbenazine)			Specify:
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### 7. Diagnosis:

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the requested medication being prescribed by or its use overseen by a neurologist or a psychiatrist?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a diagnosis of Huntington-induced chorea in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a diagnosis of tardive dyskinesia in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If yes</b> , is the requested medication Austedo (deutetrabenazine)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a diagnosis of severe depression or suicide attempt/ideation in the last 180 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a diagnosis of hepatic impairment in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have one claim for an MAO inhibitor in the last 90 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have one claim for a strong CYP2D6 inhibitor in the last 90 days? ( <b>Please note:</b> examples of strong CYP2D6 inhibitors include but are not limited to Aplenzin, Brisdelle and Bupropion.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the patient had a treatment failure with any preferred drug?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a contraindication or allergic reaction to a preferred drug?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient is being treated for stage-four advanced, metastatic cancer
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of long QT syndrome in the last 365 days?

Medicaid Preferred Drug List, please refer to the Texas Medicaid Vendor Drug Program website at <http://www.txvendordrug.com/formulary/formulary-search.asp>.

**9. Physician signature**

\_\_\_\_\_  
Prescriber or authorized signature

\_\_\_\_\_  
Date

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.*

**Note:** Payment is subject to member eligibility. Authorization does not guarantee payment.

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