Wellpoint

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

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**
**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.**

| **1. Patient information** | **2. Physician information** |
|---|---|
| Patient name: _____<br>Patient ID #: _____<br>Patient DOB: _____<br>Date of Rx: _____<br>Patient phone #: _____<br>Patient email address: _____ | Prescribing physician: _____<br>Physician address: _____<br>Physician phone #: _____<br>Physician fax #: _____<br>Physician specialty: _____<br>Physician DEA: _____<br>Physician NPI #: _____<br>Physician email address: _____ |

| **3. Medication** | **4. Strength** | **5. Directions** | **6. Quantity per 30 days** |
|---|---|---|---|
| | | | Specify: |
| **7. Diagnosis** | | | |

**8. Approval criteria:** Item (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.)

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

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|---|
| For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https:// txvendordrug.com/formulary/formulary-search** |

**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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