Pharmacy Drug Policy Checklist

POLICY NAME	Austedo (deutetrabenazine)	POLICY #	2590P

Criteria

Coverage Criteria for Huntington's Disease

- ☐ **1.1** Diagnosis of chorea, or movement disorder, associated with Huntington's Disease
- ☐ **1.2** Ordered by a neurologist (central nervous system doctor)
- ☐ **1.3** Age 18 years or older
- ☐ **1.4** Documented inadequate treatment response, intolerance, or contraindication to tetrabenazine

Coverage Criteria for Tardive Dyskinesia

- ☐ **2.1** Documented diagnosis of tardive dyskinesia and score of ≥10 on the Abnormal Involuntary Movement Scale (AIMS) or ≥20 on the Extrapyramidal Symptom Rating Scale (ESRI)
- ☐ **2.2** Ordered by a neurologist (central nervous system doctor) or psychiatrist (doctor who specializes in mental health)
- ☐ **2.3** Age 18 or older
- ☐ **2.4** Documented inadequate treatment response, intolerance, or contraindication to TWO of the following:
  - Clonazepam
  - Benztropine
  - Second generation antipsychotic (such as clozapine, quetiapine)
  - Tetrabenazine