

POLICY NAME	Austedo (deutetrabenazine)	POLICY #	2590P
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Criteria

Coverage Criteria for Huntington's Disease

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

Coverage Criteria for Tardive Dyskinesia

- ☐ 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)
- ☐ Ordered by a neurologist (central nervous system doctor) or psychiatrist (doctor who specializes in mental health)
- ☐ Age 18 or older
- ☐ Documented inadequate treatment response, intolerance, or contraindication to TWO of the following:
 - Clonazepam
 - Benztropine
 - Second generation antipsychotic (such as clozapine, quetiapine)
 - Tetrabenazine