**CNS Movement Disorders**

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| Criteria 1 | Austedo (P, PA, ST) |
| Criteria 2 | Ingrezza (P, PA), Tetrabenazine (P, PA) |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Movement Disorders | | |
| **Criteria Subtitle** | Austedo | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**     |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AUSTEDO | 077269 | GCNSeqNo |
| AUSTEDO | 077270 | GCNSeqNo |
| AUSTEDO | 077271 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1000 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1001 |
| Continuation (re-authorization request) | 1234 |
| 2 | 1001 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1002 |
| N | 1235 |
| 3 | 1002 |  | Select | Is the medication being prescribed by or in consultation with a neurologist or a psychiatrist? | Y | 1003 |
| N | 1235 |
| 4 | 1003 |  | Select | What is the patient’s diagnosis? | Tardive Dyskinesia | END (Pending Manual Review) |
| Huntington’s Disease | 1004 |
| Other | 1235 |
| 5 | 1004 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days to a maximally tolerated dose of tetrabenazine?  If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

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| **Last Approved** | 4/18/2023 |
| **Other** |  |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Movement Disorders | | |
| **Criteria Subtitle** | Ingrezza, Tetrabenazine | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**     |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| INGREZZA | 077294 | GCNSeqNo |
| INGREZZA | 077791 | GCNSeqNo |
| INGREZZA | 079676 | GCNSeqNo |
| INGREZZA | 082227 | GCNSeqNo |
| TETRABENAZINE | 017750 | GCNSeqNo |
| TETRABENAZINE | 064582 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1000 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1001 |
| Continuation (re-authorization request) | 1234 |
| 2 | 1001 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1002 |
| N | 1235 |
| 3 | 1002 |  | Select | Is the medication being prescribed by or in consultation with a neurologist or a psychiatrist? | Y | END (Approve x 365 days) |
| N | 1235 |
| 4 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 days) |
| N | 1235 |
| 5 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

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| --- | --- |
| **Last Approved** | 4/18/2023 |
| **Other** |  |