



**NC Medicaid  
Pharmacy Prior Approval Request for  
Movement Disorders: Austedo and Austedo XR**

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days): Initial Request:  up to 30 Days  60 Days  90 Days  120 Days  180 Days  
Continuation Request:  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days

**Clinical Information**

**Tardive Dyskinesia:**

1. Does the beneficiary have a diagnosis of moderate to severe Tardive Dyskinesia?  Yes  No
2. Is the beneficiary age 18 or older?  Yes  No
3. Has the provider completed baseline evaluations of the condition using either Abnormal Involuntary Movement Scale(AIMS) or Extrapyramidal Symptom Rating Scale (ESRI) along with this request?  Yes  No
- 3b. Please include **AIMS score:** \_\_\_\_\_ or **ESRI score:** \_\_\_\_\_
4. Has the beneficiary had a previous trial of an alternative method to manage the condition?  Yes  No
5. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors?  Yes  No
6. Is the beneficiary concurrently using a MAOI (monoamine oxidase inhibitor) or reserpine?  Yes  No

*For Continuation of Therapy, answer questions 1-6, and attach documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.*

**Huntington's Disease:**

7. Does the beneficiary have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea?  Yes  No
8. Is the beneficiary age 18 or older?  Yes  No
9. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors?  Yes  No
10. Is the beneficiary concurrently using a MAOI (monoamine oxidase inhibitor) or reserpine?  Yes  No
11. Does the beneficiary have a history of depression or suicidal ideation?  Yes  No
12. Is the beneficiary receiving treatment and/or is stable?  Yes  No

*For Continuation of Therapy, answer questions 7-12, and attach documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.*

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.