**NC Medicaid and NC Health Choice**
**Pharmacy Prior Approval Request for**
## Movement Disorders: Austedo

**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.

Fax this form to CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505