NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Austedo

Beneficiary Information

1. Beneficiary Last Name:______________________ 2. First Name: ________________________________
3. Beneficiary ID #:____________________ 4. Beneficiary Date of Birth:______________ 5. Beneficiary Gender: _____

Prescriber Information

7. Prescribing Provider NPI #: ____
8. Requester Contact Information
   Name:________________________________ Phone #:___________________________ Ext. _____________

Drug Information

9. Drug Name: _______ 10. Strength:_________________ 11. Quantity per 30 days: ______________________

12. Length of Therapy

Initial Request (circle # days): 30 60 90 120 180

Continuation Request (circle # days): 30 60 90 120 180 365

Clinical Information

Tardive Dyskinesia

Initial Request

1. Does the beneficiary have a diagnosis of moderate to severe Tardive Dyskinesia? ☐ Yes ☐ No
2. Is the beneficiary 18 years old or older? ☐ Yes ☐ No
3. Has the provider submitted documented baseline evaluations of the condition using either Abnormal Involuntary Movement Scale(AIMS) or Extrapyramidal Symptom Rating Scale (ESRI) along with this request? ☐Yes ☐No
4. Has the beneficiary received a previous trial of an alternative method to manage the condition? ☐Yes ☐ No
   Please list method tried ____
5. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors?
   ☐ Yes ☐No
6. Is the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐ Yes ☐ No
7. Does the beneficiary have a history of depression or suicidal ideation? ☐ Yes ☐ No
   7a. If yes, is the beneficiary being treated and/or stable? ☐ Yes ☐ No

Continuation Request for Tardive Dyskinesia (must also answer questions 1-7a above)

1. Has the beneficiary met all the above criteria for Tardive Dyskinesia? ☐ Yes ☐ No
2. Has the provider submitted documentation with this request that indicates the beneficiary has had an improvement in their symptoms from baseline? ☐ Yes ☐ No

Huntington's Disease Initial Request

1. Does the beneficiary have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea? ☐ Yes ☐ No
2. Is the beneficiary 18 years old or older? ☐ Yes ☐ No
3. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors?
   ☐ Yes ☐No
4. Is the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐ Yes ☐ No
5. Does the beneficiary have a history of depression or suicidal ideation? ☐ Yes ☐ No
   5a. If yes, is the beneficiary being treated and/or stable? ☐ Yes ☐ No

Huntington's Disease Continuation Request (must also answer questions 1-5a above)

1. Has the beneficiary met all the above criteria for Huntington's Disease? ☐ Yes ☐ No
2. Has the provider submitted documentation with this request that indicates the beneficiary has had an improvement in their symptoms from baseline? ☐ Yes ☐ No

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 NCTracks at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505