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# 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 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 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**
7. Does the beneficiary have a history of depression or suicidal ideation? ☐ **Yes** ☐ **No**
   7b. Is the beneficiary receiving treatment and/or is stable? ☐ **Yes** ☐ **No**

For Continuation of Therapy, please attach documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.

**Huntington's Disease:**

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 age 18 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 MAOI (monoamine oxidase inhibitor) or reserpine? ☐ **Yes** ☐ **No**

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5. Does the beneficiary have a history of depression or suicidal ideation? ☐ **Yes** ☐ **No**
   5b. Is the beneficiary receiving treatment and/or is stable? ☐ **Yes** ☐ **No**

For Continuation of Therapy, please 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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**