BlueCross BlueShield Federal Employee Program

AUSTEDO
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Austedo (deutetrabenazine)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 48 milligrams per day? ❑Yes***** ❑No

If YES, please specify the requested milligrams per day: _____ mg per day

1. What is the patient's diagnosis?
   - ❑Chorea associated with Huntington's disease
   - ❑Tardive dyskinesia
     - a. Has the patient been on Austedo continuously for the last **6 months**, excluding samples? ***Please select answer below:***
       - ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
         - i. Does the patient have moderate to severe tardive dyskinesia? ❑Yes ❑No
         - ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one of the following: benzodiazepine, Xenazine, or second generation antipsychotic such as Seroquel and clozapine? ❑Yes ❑No
         - iii. Is there documentation of a baseline evaluation using one of the following scoring tools: Abnormal Involuntary Movement Scale (AIMS) or Extrapyramidal Symptom Rating Scale (ESRS)? ❑Yes ❑No
         - iv. Has the prescriber reduced the dosage or discontinued all causative medications including antipsychotic medications and metoclopramide (Reglan)? ❑Yes ❑No
         - v. Does the patient have a functional impairment that justifies treatment with Austedo? ❑Yes ❑No
       - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
         - i. Is there documentation of improvement from the baseline evaluation using one of the following scoring tools: Abnormal Involuntary Movement Scale (AIMS) or Extrapyramidal Symptom Rating Scale (ESRS)? ❑Yes ❑No
   - ❑None of the above
2. Is the patient actively suicidal? ❑Yes ❑No
3. Does the patient have untreated or inadequately treated depression? ❑Yes ❑No
4. Does the patient have hepatic impairment? ❑Yes ❑No
5. Has the patient taken a MAOI (monoamine oxidase inhibitor) within the past 14 days? ❑Yes ❑No
6. Is the patient **CURRENTLY** taking reserpine? ❑Yes ❑No*****
   If NO, has the patient been on reserpine in the **PAST** 20 days? ❑Yes ❑No
7. Will this medication be used in combination with other vesicular monoamine transporter 2 (VMAT2) inhibitors such as Ingrezza (valbenzine) or Xenazine (tetrabenazine)? ❑Yes***** ❑No
   If YES, please specify the medication: _____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***