Louisiana Medicaid
Movement Disorders

The *Louisiana Uniform Prescription Drug Prior Authorization* Form should be utilized to request clinical authorization for all vesicular monoamine transporter 2 (VMAT2) inhibitors for movement disorders.

Additional Point-of-Sale edits may apply.

*Some of these agents have **Black Box Warnings** and/or are subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety Regulations. Please refer to individual prescribing information for details.*

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of:
    - Huntington's disease chorea if the requested medication is deutetrabenazine (Austedo®) or tetrabenazine (Xenazine®); **OR**
    - Moderate to severe tardive dyskinesia if the requested medication is deutetrabenazine (Austedo®) or valbenazine tosylate (Ingrezza®); **AND**
- For a non-preferred agent, there is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- For a non-preferred agent, previous use of a preferred product - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
    - The recipient is established on the medication with positive clinical outcomes; **AND**
- The recipient is not taking the requested VMAT2 inhibitor with any other VMAT2 inhibitor; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - The recipient has no contraindications to the requested therapy such as active suicidal ideation or untreated, undertreated or inadequately treated depression with Huntington's disease; hepatic impairment; concomitant therapy with monoamine oxidase inhibitors (MAOIs) or reserpine; or congenital or acquired

long QT syndrome. For a complete list, see the corresponding current prescribing information; **AND**

- All laboratory testing and clinical monitoring recommended in the prescribing information have been completed (as of the date of the request) at baseline, every six months, and with dosage changes, and will be repeated as recommended in the prescribing information; **AND**
- The recipient has no inappropriate concomitant drug therapies or disease states**.**

Reauthorization Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that the recipient is established on the requested medication with evidence of a positive response to therapy.

Duration of Initial and Reauthorization Approval: 12 months

References

Austedo (deutetrabenazine) [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc; February 2020. https://www.austedo.com/hcp/renderpdf.aspx?file=PrescribingInformation.pdf

Ingrezza (valbenazine) [package insert]. San Diego, CA: Neurocrine Biosciences, Inc; April 2020. https://www.ingrezza.com/PI/

Xenazine (tetrabenazine) [package insert]. Deerfield, IL: Lundbeck; November 2019. http://www.lundbeck.com/upload/us/files/pdf/Products/Xenazine_PI_US_EN.pdf

Revision	**Date**
Policy created	June 2018
Clarified Huntington's disease contraindication, formatting changes, updated references	June 2020
Added non-preferred criteria wording	October 2020