SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed.**

Movement Disorders Medications

Drug Requested: (Check below the drug that applies)

PREFERRED	
❑ **Austedo®** (deutetrabenazine) **tablet**	❑ **Austedo XR®** (deutetrabenazine) **tablet**
❑ **Austedo®** (deutetrabenazine) **XR titration Pack**	❑ **Ingrezza®** (valbenazine) **capsule**
❑ **Ingrezza®** (valbenazine) **Initiation Pack**	❑ **tetrabenazine** (generic Xenazine®) **tablet**
❑ **Xenazine®** (tetrabenazine) **tab**	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

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Drug	Quantity Limits
Austedo® tab/Austedo XR tab	• **Maximum Quantity limit:** 4 tablets per day
Austedo® XR titration pack	• **Maximum Quantity limit:** 42 tablets per 365 days
Ingrezza® cap	• **Maximum Quantity limit:**1 capsule per day
Xenazine® tab and tetrabenazine (generic Xenazine®)	• **Maximum Quantity limit:** 4 tablets per day

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must be 18 years of age or older

AND

- ❑ Prescribed by or in consultation with a neurologist or psychiatrist

AND

- ❑ Member must have a diagnosis of:
  - ❑ Tardive Dyskinesia

OR

  - ❑ Huntington's disease

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****