pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

VMAT2 INHIBITORS PRIOR AUTHORIZATION FORM *(form effective 5/1/2023)*

Prior authorization guidelines for VMAT2 Inhibitors and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Dosage form:
Strength:	Quantity:	Refills:
Dose/directions:		
Diagnosis *(submit documentation)*:		Dx codes (*required*):
Is the requested medication being prescribed by or in consultation with a specialist (ie., neurologist or psychiatrist)?		☐Yes ☐No *Submit documentation of consultation if applicable.*

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

ALL requests (initial and renewal)

☐For AUSTEDO (DEUTETRABENAZINE):
- ☐Has a contraindication to Austedo *(check all that apply)*:
  - ☐Actively suicidal
  - ☐Hepatic impairment
  - ☐Taking Xenazine or Ingrezza
  - ☐Taken an MAO inhibitor in the past 14 days (eg, phenelzine, rasagiline, selegiline, tranylcypromine)
  - ☐Taken reserpine in the past 20 days
  - ☐Depression that is untreated or inadequately treated
- ☐Is known to be a poor CYP2D6 metabolizer
  - ☐Austedo dose is adjusted accordingly based on dosing recommendations in the package labeling
- ☐Will be taking a strong CYP2D6 inhibitor while taking Austedo (e.g., bupropion, fluoxetine, paroxetine, quinidine)
  - ☐Austedo dose is adjusted accordingly based on dosing recommendations in the package labeling

☐For INGREZZA (VALBENAZINE):
- ☐Is taking a strong CYP3A4 inhibitor (eg, some azole antifungals, nefazodone, some protease inhibitors)
  - ☐Ingrezza dose is adjusted accordingly based on dosing recommendations in the package labeling
- ☐Is taking a strong CYP2D6 inhibitor (eg, bupropion, fluoxetine, paroxetine, quinidine)
  - ☐Ingrezza dose is adjusted accordingly based on dosing recommendations in the package labeling

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☐ Has moderate or severe hepatic impairment (Child-Pugh score 7 to 15)
  ☐ Ingrezza dose is adjusted accordingly based on dosing recommendations in the package labeling
☐ Is taking a strong CYP3A4 inducer (eg, carbamazepine, phenytoin, rifampin, St. John's Wort) *(concomitant use not recommended per package labeling)*

☐ For XENAZINE (TETRABENAZINE):
☐ Has a contraindication to tetrabenazine / Xenazine *(check all that apply)*:
  ☐ Actively suicidal
  ☐ Hepatic impairment
  ☐ Taking Austedo or Ingrezza
  ☐ Taken an MAO inhibitor in the past 14 days (eg, phenelzine, rasagiline, selegiline, tranylcypromine)
  ☐ Taken reserpine in the past 20 days
  ☐ Depression that is untreated or inadequately treated
☐ Will be taking a strong CYP2D6 inhibitor while taking tetrabenazine (eg, bupropion, fluoxetine, paroxetine, quinidine)
  ☐ Tetrabenazine dose is adjusted accordingly based on dosing recommendations in the package labeling
☐ Is prescribed a tetrabenazine dose that exceeds 50 mg per day
  ☐ Has documentation of therapeutic failure of tetrabenazine at a dose of ≤50 mg/day
  ☐ Has documentation of CYP450 2D6 genotyping showing intermediate or extensive metabolism

INITIAL requests

☐ Had a mental health evaluation
☐ Has a history of suicide attempt, bipolar disorder, or major depressive disorder
  ☐ Was evaluated in the past 6 months and treated by a psychiatrist
☐ Was determined to be a candidate for treatment with the requested medication based on the mental health evaluation

☐ For treatment of TARDIVE DYSKINESIA:
☐ Has no other causes of involuntary movement
☐ Has documentation of tardive dyskinesia severity using a validated scale or assessment of impact on daily function
☐ A decrease in dose of dopamine receptor blocking agents is not appropriate

RENEWAL requests

☐ Was reevaluated for new onset or worsening symptoms of depression
  ☐ If applicable, was or is being treated for symptoms of depression
☐ Was determined to remain a candidate for treatment with the requested medication based on the mental health evaluation

☐ For treatment of CHOREA:
☐ Experienced clinical benefit from the requested medication based on the prescriber's clinical judgement

☐ For treatment of TARDIVE DYSKINESIA:
☐ Experienced an improvement in tardive dyskinesia severity documented by a validated scale
☐ Experienced an improvement in daily functioning

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

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