Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Austedo

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for reauthorization of Austedo?

☐ Yes ☐ No

Q2. For Tardive Dyskinesia (TD): does the member have an improvement in symptoms related to tardive dyskinesia with an updated abnormal involuntary movement scale (AIMS) with assessment attached?

☐ Yes ☐ No

Q3. For Chorea associated with Huntington's Disease: does the member have stabilization or improvement in symptoms of Chorea with medical records attached?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is Austedo being prescribed by or in consultation with a neurologist or psychiatrist?

☐ Yes ☐ No

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Q6. Does the patient have a documented diagnosis of Tardive Dyskinesia? If YES, go to 7. If NO go to 10.

☐ Yes ☐ No

Q7. Has a copy of the abnormal involuntary movement scale (AIMS) assessment been attached?

☐ Yes ☐ No

Q8. Is there documentation that other movement disorders (such as Parkinson's disease, chorea associated with Huntington's disease) have been excluded? Documentation must be attached.

☐ Yes ☐ No

Q9. Does the patient have a current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine, etc)? Please attach documentation. If YES, go to 13.

☐ Yes ☐ No

Q10. Does the patient have the diagnosis of chorea associated with Huntington's disease?

☐ Yes ☐ No

Q11. Have other movement disorders (such as tardive dyskinesia, Parkinson's disease) been excluded with documentation attached?

☐ Yes ☐ No

Q12. Is the patient suicidal or is untreated or inadequately treated for depression?

☐ Yes ☐ No

Q13. Have all other potential contraindications (including congenital long QT syndrome, history of cardiac arrhythmias, hepatic impairment) been excluded?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q14. Will the patient be treated concurrently with a monoamine oxidase (MAO) inhibitor, reserpine, tetrabenazine or valbenazine?

☐ Yes ☐ No

Q15. Requested Duration:

☐ 12 Months ☐ Other

Q16. Additional Information:

Prescriber Signature

Date

v2026