



**2024 PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Austedo**

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.**

|  |   |
|--|---|
| <b>Patient Name:</b>                                     | <b>Prescriber Name:</b>                         |
| Member Number:   | Fax: Phone:                                     |
| Date of Birth:   | Office Contact:                                 |
| Line of Business: <input type="checkbox"/> Exchange - PA | NPI: State Lic ID:                              |
| Address:   | Address:  |
| City, State ZIP:   | City, State ZIP:                                |
| Primary Phone:   | <b>Specialty/facility name (if applicable):</b> |

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the 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. Does the patient have the diagnosis of tardive dyskinesia?

Yes

No

Q2. Has the patient been previously approved for treatment with Austedo?

Yes

No

Q3. 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

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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|  |                         |
|--|-------------------------|
| <b>Patient Name:</b>   | <b>Prescriber Name:</b> |
| Q6. Has a copy of the abnormal involuntary movement scale (AIMS) assessment been attached?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                         |
| Q7. 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                         |
| Q8. 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                         |
| Q9. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged qt interval, for a diagnosis of Chorea associated with Huntington's Disease: suicidal patients and patients with untreated or inadequately treated depression) been excluded?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                         |
| Q10. Will the patient be treated concurrently with a monoamine oxidase (MAO) inhibitor?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                         |
| Q11. Does the patient have the diagnosis of chorea associated with Huntington's disease?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                         |
| Q12. Has the patient been previously approved for treatment with Austedo?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                         |
| Q13. Does the member have a documented improvement in symptoms of chorea with medical records attached?  |                         |



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|   |                             |
|---|-----------------------------|
| <b>Patient Name:</b>  | <b>Prescriber Name:</b>     |
| <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Q14. Is the patient 18 years of age or older?   |                             |
| <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Q15. Is Austedo being prescribed by or in consultation with a neurologist or psychiatrist?  |                             |
| <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Q16. Have other movement disorders (such as Parkinson's disease, tardive dyskinesia) been excluded with documentation attached?                     |                             |
| <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Q17. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged QT interval) been excluded? |                             |
| <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Q18. Will the patient be treated concurrently with a monoamine oxidase (MAO) inhibitor?   |                             |
| <input type="checkbox"/> Yes  | <input type="checkbox"/> No |
| Q19. Additional Information:  |                             |

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2024 Prior Authorization Request