Prescriber Criteria Form

Austedo 2026 PA Fax 1748-A v2 010126.docx
Austedo (deutetrabenazine), Austedo XR (deutetrabenazine extended-release)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Austedo.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of tardive dyskinesia? [If no, then skip to question 5.]	Yes	No
2	Is the patient currently receiving therapy with the requested drug? [If yes, then skip to question 8.]	Yes	No
3	Does the patient exhibit clinical manifestations of the disease? [If no, then no further questions.]	Yes	No
4	Has the patient's disease been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS])? [No further questions.]	Yes	No
5	Is the requested drug being prescribed for the treatment of chorea associated with Huntington's disease? [If no, then no further questions].	Yes	No
6	Is the patient currently receiving therapy with the requested drug? [If yes, then skip to question 8.]	Yes	No
7	Does the patient demonstrate characteristic motor examination features? [No further questions.]	Yes	No

8	Has the patient demonstrated a beneficial response to therapy?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____