AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Austedo-Austedo XR		Page:	1 of 2
Effective Date:	8/1/2024		Last Review Date:	7/3/2024
Applies to:	☐Illinois ☒Pennsylvania Kids	☐Virginia ☒Florida Kids	☒New Jersey ☒Maryland	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Austedo under the patient's prescription drug benefit.

Description:

FDA-Approved Indications

A. Treatment of chorea associated with Huntington's disease
B. Treatment of tardive dyskinesia in adults

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Austedo
Austedo XR

Policy/Guideline:

Documentation:
Submission of the following information is necessary for both initial approval and continuation of therapy prior authorization reviews: Documentation of score of items 1 to 7 of the Abnormal Involuntary Movement Scale (AIMS) for tardive dyskinesia.

Criteria for Initial Approval:

A. Tardive dyskinesia
Authorization of 6 months may be granted for treatment of tardive dyskinesia when the baseline AIMS score for items 1 to 7 is obtained

B. Chorea associated with Huntington's disease
Authorization of 6 months may be granted for treatment of chorea associated with Huntington's disease when both of the following criteria are met:
1. Member demonstrates characteristic motor examination features
2. Member meets one of the following conditions:
   i. Laboratory results indicate an expanded *HTT* CAG repeat sequence of at least 36
   ii. Member has a positive family history for Huntington's disease

Criteria for Continuation of Therapy:

A. Tardive dyskinesia
Authorization of 12 months may be granted for treatment of tardive dyskinesia when the member's tardive dyskinesia symptoms have improved as indicated by a decreased AIMS score (items 1 to 7) from baseline.

B. Chorea associated with Huntington's disease
Authorization of 12 months may be granted for treatment of chorea associated with Huntington's disease when the disease has improved or stabilized.

Approval Duration and Quantity Restrictions:

Approval:

- **Initial:** 6 months
- **Renewal:** 12 months

Quantity Level Limit:

- Austedo 6 mg tablet: 60 per 30 days
- Austedo 9 mg tablet: 120 per 30 days
- Austedo 12 mg tablet: 120 per 30 days
- Austedo XR 6 mg tablet: 90 tablets per 30 days
- Austedo XR 12 mg tablet: 120 tablets per 30 days
- Austedo XR 24 mg tablet: 60 tablets per 30 days
- Austedo XR Titration Kit (6 mg, 12 mg, and 24 mg tablets): 42 tablets per 90 days
- Austedo XR 30mg tablet: 30 tablets per 30 days
- Austedo XR 36mg tablet: 30 tablets per 30 days
- Austedo XR 42mg tablet: 30 tablets per 30 days
- Austedo XR 48mg tablet: 30 tablets per 30 days

References:

1. Austedo [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc. June 2021.
2. Frank S, Testa CM, Stamler D, et al. Effect of deutetrabenazine on chorea among patients with Huntington disease: A randomized clinical trial. Huntington Study Group. *JAMA.* 2016;316(1):40-50.
3. Fernandez HH, Factor SA, Hauser RA, et al. Randomized controlled trial of deutetrabenazine for tardive dyskinesia: The ARM-TD study. *Neurology.* 2017;88:2003-10.
4. Anderson KE, Stamler D, Davis MD, et al. Deutetrabenazine for treatment of involuntary movements in patients with tardive dyskinesia (AIM-TD): a double-blind, randomized, placebo-controlled, phase 3 trial. *Lancet Psychiatry.* 2017;4: 595-604.
5. American Psychiatric Association. (2021). *Practice Guideline for the Treatment of Patients With Schizophrenia, third edition.* https://doi.org/10.1176/appi.books.9780890424841