



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Austedo-Austedo XR

Page: 1 of 2

Effective Date: 1/13/2024

Last Review Date: 12/2023

Applies to:	<input checked="" type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Maryland
	<input type="checkbox"/> New Jersey	<input type="checkbox"/> Florida Kids	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Texas

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:

I. DOCUMENTATION:

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

II. CRITERIA FOR INITIAL APPROVAL:

A. Tardive dyskinesia

Authorization 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 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

III. CRITERIA FOR CONTINUATION OF THERAPY:



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A. Tardive dyskinesia

Authorization may be granted for treatment of tardive dyskinesia when the member's tardive dyskinesia symptoms have improved.

B. Chorea associated with Huntington's disease

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

Approval Duration and Quantity Restrictions:

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

Quantity Level Limits:

- Austedo 6 mg tablet: 120 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

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>