Clinical Policy Title:	deutetrabenazine
Policy Number:	RxA.349
Drug(s) Applied:	Austedo®, Austedo® XR
Original Policy Date:	03/06/2020
Last Review Date:	08/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Huntington's Disease (must meet all)**:**

1. Diagnosis of chorea associated with Huntington's disease;
2. Trial and failure of tetrabenazine at up to 100 mg/day, unless contraindicated or clinically significant adverse effects are experienced;
3. At the time of request, reserpine, MAOIs, tetrabenazine, or valbenazine is not prescribed concurrently.

Approval duration

All Lines of Business (except Medicare): 6 months

B. Tardive Dyskinesia (must meet all)**:**

1. Diagnosis of tardive dyskinesia secondary to a centrally acting dopamine receptor blocking agent (DRBA);
2. At the time of request, reserpine, MAOIs, tetrabenazine, or valbenazine is not prescribed concurrently.

Approval duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all)**:**

1. Member is currently receiving or has been treated with this medication within the past 120 days, excluding manufacturer samples.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. Claassen DO, Carroll B, De Boer LM, et al. Indirect tolerability comparison of Deutetrabenazine and Tetrabenazine for Huntington disease. J Clin Mov Disord. 2017;4:3. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5331691/. Accessed August 28, 2024.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR. American Psychiatric Association Publishing; 2022. Available at: https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date

Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Policy title table was updated. 2. Continued therapy criteria II.A.1 was rephrased to “Currently receiving medication that has been authorized by RxAdvance…”. 3. Age symbols and approval duration was updated in initial and continued therapy approval. 4. Updating initial and continued therapy approval criteria to include avoidance of concurrent reserpine and MAOI therapy. 5. QD was updated to "once daily" in document. 6. References were updated.	08/26/2020	09/14/2020
Policy was reviewed. 1. Initial Therapy Criteria and Continued Therapy Criteria have been updated to remove approval duration for HIM. 2. References were reviewed and updated.	06/01/2021	09/14/2021
Policy was reviewed: 1. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. References were reviewed and updated.	03/16/2022	07/18/2022
Policy was reviewed. 1. References were reviewed and updated.	03/28/2023	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with the new verbiage containing 120 days lookback period. 5. Removed other reauthorization requirements including positive response to therapy. 6. Updated approval duration verbiage.	08/28/2024	9/13/2024

7. References were reviewed and updated.		