

Reference number(s)
1746-A

SPECIALTY GUIDELINE MANAGEMENT

AUSTEDO (deutetrabenazine)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. Treatment of chorea associated with Huntington's disease
2. Treatment of tardive dyskinesia in adults

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Chorea associated with Huntington disease

Authorization of 12 months may be granted for treatment of chorea associated with Huntington disease.

Tardive dyskinesia

Authorization of 12 months may be granted for treatment of tardive dyskinesia.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Austedo [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc. August 2017.