Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Austedo - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have the diagnosis of tardive dyskinesia?
If No, go to 11.

☐ Yes ☐ No

Q2. Has the patient been previously approved for treatment with Austedo?
If No, go to 4.

☐ Yes ☐ No

Q3. Does the member have a documented improvement in symptoms related to tardive dyskinesia with an updated abnormal involuntary movement scale (AIMS) with assessment attached?
If Yes, go to 19.

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is Austedo being prescribed by, or in consultation with, a neurologist or psychiatrist?

☐ Yes ☐ No

Q6. Has a copy of the abnormal involuntary movement scale (AIMS) assessment been attached?

☐ Yes ☐ No

Q7. Is there documentation that other movement disorders (such as Parkinson's disease, chorea associated with

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Huntington's disease) have been excluded?
Documentation must be attached.

☐ Yes ☐ No

Q8. Does the patient have a current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine, etc)?
Must attach documentation.

☐ Yes ☐ No

Q9. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged QT interval) been excluded?

☐ Yes ☐ No

Q10. Will the patient be treated concurrently with a monoamine oxidase (MAO) inhibitor?
If Yes, go to 19.

☐ Yes ☐ No

Q11. Does the patient have the diagnosis of chorea associated with Huntington's disease?

☐ Yes ☐ No

Q12. Has the patient been previously approved for treatment with Austedo?

☐ Yes ☐ No

Q13. Does the member have a documented improvement in symptoms of chorea with medical records attached?
Must attach documentation.
If Yes, go to 19.

☐ Yes ☐ No

Q14. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q15. Is Austedo being prescribed by or in consultation with a neurologist or psychiatrist?

☐ Yes ☐ No

Q16. Have other movement disorders (such as Parkinson's disease, tardive dyskinesia) been excluded with documentation attached?

☐ Yes ☐ No

Q17. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged QT interval) been excluded?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q18. Will the patient be treated concurrently with a monoamine oxidase (MAO) inhibitor?

☐ Yes ☐ No

Q19. Additional Information:

Q20. Requested Duration:

☐ 12 Months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request