Mass General Brigham
Health Plan

Austedo (deutetrabenazine)
Austedo XR (deutetrabenazine extended-release)
Effective 10/1/2024

Plan	☐ MassHealth UPPL ☒ Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Austedo (deutetrabenazine)/Austedo XR (deutetrabenazine extended-release) is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated in adults for the treatment of:

- Chorea associated with Huntington's disease
- Tardive dyskinesia.

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:
Chorea associated with Huntington's disease

1. Member has a diagnosis of chorea associated with Huntington's disease

Tardive dyskinesia

1. Member has a diagnosis of tardive dyskinesia

Continuation of Therapy
Reauthorization may be granted when the following criteria are met:

1. Documentation the member's condition has improved

Limitations

1. Initial approvals will be granted for 6 months
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

Drug Name	Quantity Limit
Austedo 6mg and 9mg	2 tablets per day
Austedo 12mg	4 tablets per day
Austedo XR	1 tablet per day

References

1. Austedo/Austedo XR (deutetrabenazine) [prescribing information]. Parsippany, NJ: Teva Neuroscience, Inc; July 2024.
2. 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.
3. Fernandez HH, Stamler D, Davis MD, et al. Long-term safety and efficacy of deutetrabenazine for the treatment of tardive dyskinesia. J Neurol Neurosurg Psychiatry 2019; 90:1317
4. Huntington Study Group, Frank S, Testa CM, et al. Effect of Deutetrabenazine on Chorea Among Patients with Huntington Disease: A Randomized Clinical Trial. JAMA 2016; 316:40v
5. Ricciardi L, Pringsheim T, Barnes TRE, et al. Treatment Recommendations for Tardive Dyskinesia. Can J Psychiatry 2019; 64:388.

Review History

05/19/2021- Reviewed and Updated for May P&T; change from SGM to custom template; added required trial of tetrabenazine for Chorea to align with MH; added QL and approval durations to Limitations. Effective 08/01/2021.
09/21/2022- Reviewed P&T; references updated; Separated out Comm/Exch vs. MH.
08/14/2024 – Reviewed at August P&T. Added Austedo XR to the policy with a quantity limit. Removed age requirement. Updated criteria to require attestation of diagnosis of tardive dyskinesia or chorea associated with Huntington's disease. Updated criteria for tardive dyskinesia to remove requirement that the member experiences persistent and disabling or intrusive tardive dyskinesia. Increased initial approval length from 3 months to 6 months. Clarified step therapy language to indicate member must be new to the plan within the past 90 days. Effective 10/1/2024.