

Austedo (deutetrabenazine)
Austedo XR (deutetrabenazine extended-release)
Effective 08/01/2025

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 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 the following diagnosis-specific criteria are met:

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 and Dosage Form	Quantity Limit
Austedo 6 mg and 9 mg tablets	2 tablets per day
Austedo 12mg tablets	4 tablets per day

Austedo XR tablets	1 tablet per day
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References

1. Austedo/Austedo XR (deutetrabenazine) [prescribing information]. Parsippany, NJ: Teva Neuroscience, Inc; February 2025.
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.

07/11/2025 – Reviewed at July P&T. No clinical changes. Effective 08/01/2025.

