Please complete ALL information below and fax your request to 1-888-671-5285

Austedo® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Chorea associated with Huntington's disease
- ❑ Moderate to severe tardive dyskinesia
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Austedo is prescribed by or in consultation with one of the following specialists:

- ❑ Neurologist
- ❑ Psychiatrist

For tardive dyskinesia, answer the following:

Is the patient a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication? ❑ **Yes** ❑ **No**

If "yes" to the above, does the patient have persistent symptoms of tardive dyskinesia despite a trial dose reduction, tapering, or discontinuation of the offending medication? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Is there documentation the patient has had a positive clinical response to Austedo therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

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