STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

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Office of Pharmacy Services
Prior Authorization Criteria
VMAT Inhibitors
Xenazine® (tetrabenazine), Austedo® (deutetrabenazine), Ingrezza™ (valbenazine)
Effective 09/24/2025

Prior Authorization Request Form

Xenazine (tetrabenazine) is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with chorea associated with Huntington's disease.

Austedo (deutetrabenazine) is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with chorea associated with Huntington's disease and for the treatment of tardive dyskinesia in adults.

Ingrezza (valbenazine) is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with tardive dyskinesia and for the treatment of adults with chorea associated with Huntington's disease.

Xenazine (tetrabenazine) CRITERIA FOR APPROVAL:

1. Patient must have a diagnosis of Chorea associated with Huntington's disease; **AND**
2. Must be prescribed by a M.D./D.O. or a specialty trained prescriber with a clinical specialty certification/degree in neurology; **AND**
3. The patient must be within the age range as recommended by the Food and Drug Administration (FDA) label; **AND**
4. Patient must have been evaluated and found not to be suicidal or have untreated/undertreated depression; **AND**
5. The prescribed dose must be provided and within dosing recommendations per the manufacturer label; **AND**
6. Patient must not be taking an MAOI (at least 14-days post-therapy), reserpine (must be >20 days post therapy) or any other concurrent VMAT2 inhibitor.

Approval Duration: Initial approval will be for 90 days.

Criteria for reauthorization: Continuation of therapy will be granted for 12 months.

1. Demonstrate continued documented compliance; **AND**
2. Documentation of positive clinical response and/or stabilization of symptoms must be provided.

Austedo (deutetrabenazine) and Ingrezza (valbenazine) CRITERIA FOR APPROVAL:

Initial* Prior Authorization Criteria:

- The patient must be within the age range as recommended by the FDA label; **AND**
- Patient must not be taking an MAOI (at least 14-days post-therapy), reserpine (must be >20 days post therapy) or any other concurrent VMAT2 inhibitor; **AND**
- Prescriber must provide a brief description of the medical necessity of therapy by documenting all target symptoms and their impact on the patient's function and activities of daily living; **AND**

Treatment of Chorea associated with Huntington's Disease:

1. Must be prescribed by a M.D./D.O. or a specialty trained prescriber with a clinical specialty certification/degree in neurology; **AND**
2. Patient must have been evaluated and found not to be suicidal or have untreated/undertreated depression; **AND**
3. All previous therapies must be documented along with their relative benefit. Unless contraindicated, the patient must have a documented 90-day trial, which resulted in intolerance or inadequate treatment response, to **Xenazine (tetrabenazine)**.

Treatment of Tardive Dyskinesia (TD):

1. Must be prescribed by a M.D./D.O. or a specialty trained prescriber with a clinical specialty certification/degree in neurology or psychiatry; **AND**
2. Patient must provide a documented clinical diagnosis of tardive dyskinesia meeting DSM-V criteria including:
    a) Involuntary athetoid or choreiform movements
    b) History of treatment with a dopamine receptor blocking agent (DRBA) such as an antipsychotic or metoclopramide
    c) Symptom duration lasting at least 8 weeks; **AND**
3. Prescriber must submit the results of an Abnormal Involuntary Movement Scale (AIMS) exam with every request for prior authorization of Austedo; **AND**
4. Prescriber must submit documentation of all other therapies attempted and their associated benefit **(including relevant AIMS scores)**.

Approval Duration: Initial approval will be for 90 days.

Criteria for reauthorization: Continuation of therapy will be granted for 12 months.

1. Demonstrate continued documented compliance; **AND**
2. Documentation of significant improvement in symptoms compared to that seen in previous therapy must be provided.