Vesicular Monoamine Transporter 2 (VMAT2) Inhibitor Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (Credentials)

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name | Strength | Duration (if applicable) | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

- Will the patient take the requested medication concurrently with reserpine? ☐ Yes ☐ No
- Will the patient take the requested medication concurrently with a monoamine oxidase inhibitor (MAOI)? ☐ Yes ☐ No
  - If yes, please specify which MAOI will be used concurrently.
- Will the patient take the requested medication concurrently with another vesicular monoamine transporter 2 (VMAT2) inhibitor? ☐ Yes ☐ No
  - If yes, please specify which other VMAT2 inhibitor will be used concurrently.
- If the prescriber is a mid-level practitioner (i.e. nurse practitioner, physician assistant, etc), does the prescriber have a clinical specialty certification/degree in neurology? ☐ Yes ☐ No
  - If yes, please indicate the clinical specialty certificate/degree and the accrediting body.

Please briefly describe the target symptoms being treated and their impact on the patient's function and activities of daily living.

Please choose and complete **only one** of the following two diagnosis areas:

Diagnosis: Huntington's Chorea

Initial Authorization:

Does the patient currently have untreated or undertreated depression? ☐ Yes ☐ No

Is the patient currently reporting symptoms of suicidal ideation? ☐ Yes ☐ No

Please list all previously attempted medications for Huntington's Chorea.
For each medication trial, please include the medication name, strength, directions, start date, end date, and outcome.

Re-Authorization:

Please briefly describe the patient's response to therapy and change in symptoms since starting the requested medication.

Diagnosis: Tardive Dyskinesia

Initial Authorization:

Does the patient have athetoid or choreiform movements? ☐ Yes ☐ No

Does the patient have a history of treatment with a dopamine receptor blocking agent (DRBA)? ☐ Yes ☐ No

If yes, please specify which DRBA(s) the patient has previously taken.

How long has the patient experienced symptoms of tardive dyskinesia?

Please list all previously attempted medications for tardive dyskinesia.
For each medication trial, please include the medication name, strength, directions, start date, end date, and outcome.
Please also attach relevant Abnormal Involuntary Movement Scale (AIMS) scores from each trial.

Please attach the patient's most recent AIMS score.

Re-Authorization:

Please attach the patient's most recent AIMS score.

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)