

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



[[PANUMCODE]]

Austedo, Austedo XR

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at 1-866-814-5506. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

ICD-10 Code: _____

Prescribed Drug and Dosage Form: _____

Is a loading dose required: Yes No

Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

1. Is this a request for continuation of therapy with the requested drug? Yes No *If No, skip to #6*
2. Is the patient currently receiving the requested drug through samples (including starter pack obtained from healthcare professional) or a manufacturer's patient assistance program?
 Yes, skip to #6
 No
 Unknown, skip to #6
3. What is the diagnosis?
 Tardive dyskinesia
 Chorea associated with Huntington's disease, skip to #5
 Other: _____
4. Have the patient's tardive dyskinesia symptoms improved as indicated by a decrease in Abnormal Involuntary Movement Scale (AIMS) score (items 1 to 7) from baseline? **ACTION REQUIRED:** If Yes, attach current AIMS score for items 1 to 7. Yes No *No further questions.*
5. Has the patient experienced stabilization or improvement in their condition since starting treatment with the requested drug? Yes No *No further questions.*
6. If the diagnosis is:
 Tardive dyskinesia, skip to #7
 Chorea associated with Huntington's disease, skip to #8
 Other: _____, *no further questions*

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

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7. Has the baseline score for items 1 to 7 of the Abnormal Involuntary Movement Scale (AIMS) been submitted?
ACTION REQUIRED: If Yes, attach baseline AIMS score for items 1 to 7.
 Yes No *No further questions.*
8. Does the patient demonstrate characteristic motor examination features? Yes No
9. Is the diagnosis supported by laboratory results demonstrating an expanded HTT CAG repeat sequence of at least 36? *If Yes, no further questions.* Yes No
10. Does the patient have a positive family history for Huntington's disease? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

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