Jefferson Health Plans

# *PRIOR AUTHORIZATION REQUEST FORM*

Individual and Family Plans

## Austedo

**Fax back to: (833) 605-4407**

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Exchange - PA | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

Q1. Is this a request for reauthorization of therapy? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Does the patient have a documented positive clinical response to therapy (i.e., updated AIMS assessment for TD, medical records confirming improvement)?

☐ Yes ☐ No

Q3. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q4. Is the drug being prescribed by or in consultation with a neurologist or psychiatrist?

☐ Yes ☐ No

Q5. Has the patient been diagnosed with tardive dyskinesia and has a copy of the Abnormal Involuntary Movement Scale (AIMS) assessment been attached? If YES, go to 6. If NO, go to 8.

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☐ Yes ☐ No

Q6. Does the patient have documentation of current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine)?

☐ Yes ☐ No

Q7. Does the member meet one of the following?

If YES, go to 10.

☐ The prescriber attests that the member continues to experience symptoms of TD despite dose reduction, tapering, or discontinuation of the offending drug(s)

☐ The prescriber attests that dose reduction, tapering, or discontinuation of the offending drug(s) would not be appropriate

Q8. Does the patient have a diagnosis of Chorea associated with Huntington's Disease with documentation of diagnosis attached?

☐ Yes ☐ No

Q9. For a diagnosis of Chorea associated with Huntington's Disease: is the patient suicidal or do they have a history of untreated or inadequately treated depression?

☐ Yes ☐ No

Q10. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged QT interval) been excluded?

☐ Yes ☐ No

Q11. Will the drug be used concurrently with any of the following: monoamine oxidase (MAO) inhibitor, strong cytochrome 3A4 (CYP3A4) inducer, reserpine, tetrabenazine, or valbenazine?

☐ Yes ☐ No

Q12. Additional Information:

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| | |

_____ _____

Prescriber Signature Date

*v2026*