Effective Date **10/15/2023**
Next Review Date **10/1/2024**
Coverage Policy Number **IP0079**

Deutetrabenazine

Table of Contents

Overview 1
Medical Necessity Criteria 1
Reauthorization Criteria 2
Authorization Duration 2
Conditions Not Covered.......................................2
Background..2
References 2

Related Coverage Resources

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This policy supports medical necessity review for the following deutetrabenazine products:

- **Austedo®** (deutetrabenazine) tablets
- **Austedo XR®** (deutetrabenazine) extended-release tablets

Receipt of sample product does not satisfy any criteria requirements for coverage.

Medical Necessity Criteria

Deutetrabenazine (Austedo and Austedo XR) are considered medically necessary when ONE of the following is met:

1. **Chorea Associated with Huntington's Disease.** Individual meets **ALL** of the following criteria:
   A. 18 years of age or older
   B. Diagnosis of Huntington's disease is confirmed by genetic testing (for example, an expanded HTT CAG repeat sequence of at least 36)

    C. Medication is prescribed by, or in consultation with, a neurologist

2. **Tardive dyskinesia.** Individual meets **ALL** of the following criteria:
    A. 18 years of age or older
    B. Documented diagnosis of tardive dyskinesia
    C. History of treatment with a dopamine receptor blocking agent (for example, antipsychotics, metoclopramide, prochlorperazine)
    D. Medication is being prescribed by, or in consultation with, a neurologist or a psychiatrist

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Reauthorization Criteria

Continuation of deutetrabenazine (Austedo and Austedo XR) is considered medically necessary for **ALL** covered diagnoses when the above medical necessity criteria are met AND there is documentation of beneficial response.

Authorization Duration

Initial approval duration is up to 12 months
Reauthorization approval duration is up to 12 months

Conditions Not Covered

Any other use is considered experimental, investigational or unproven.

Background

OVERVIEW
Austedo, a vesicular monoamine transporter type 2 inhibitor, is indicated in adults for the following uses:[1]

- Chorea associated with Huntington's disease
- Tardive dyskinesia

References

1. Austedo® tablets/Austedo® XR extended-release tablets [prescribing information]. North Wales, PA: Teva; February 2023.

"Cigna Companies" refers to operating subsidiaries of Cigna Corporation. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. © 2023 Cigna.