BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

VMAT 2 inhibitors

Policy Number: 9.204
Version Number: 2.0
Version Effective Date: 6/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan ☐ New Hampshire Medicaid	**Boston Medical Center HealthNet Plan** ☒ MassHealth - MCO ☒ MassHealth - ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- **Austedo® (deutetrabenazine)**
- **Ingrezza® (valbenazine)**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Exclusions	Prior medical history of or significant risk for: suicidal ideation, violent behavior, or unstable psychiatric symptoms.
Required Medical Information	Austedo® 1. Diagnosis of moderate to severe Tardive Dyskinesia;. **AND** a. Attestation that the member is currently on the lowest effective dose of a 2nd generation antipsychotic or other offending agent. **OR** 2. Diagnosis of chorea associated with Huntington's Disease **AND**

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

	3. The Member has demonstrated an inadequate response to or inability to tolerate tetrabenazine at max daily dose, unless contraindicated or clinically significant adverse effects are experienced. **AND** 4. Austedo is not prescribed concurrently with tetrabenazine or Ingrezza® **AND** 5. Dose does not exceed 48 mg per day. Ingrezza® 1. Diagnosis of moderate to severe Tardive Dyskinesia. **AND** 2. Attestation that the member is currently on the lowest effective dose of a 2nd generation antipsychotic or other offending agent. **AND** 3. Prior treatment failure, intolerance or contraindication ONE of the following: a. benzodiazepine b. tetrabenazine **AND** 4. Dose does not exceed 80mg per day.
Age Restriction	18 years of age or older
Prescriber Restriction	Prescribed by or in consultation with a neurologist or a psychiatrist
Coverage Duration	12 months
Other criteria	Reauthorization: 1. Clinical condition has improved or stabilized without treatment related adverse events.

Clinical Background Information and References

1. Austedo® (deutetrabenazine) [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; December 2020.
2. Austedo Micromedex®. Truven Health Analytics; Accessed May 1, 2017. http:// www. micromedexsolutions.com
3. Austedo® Lexicomp®. Walters Kluwer; Accessed August 15, 2017. Http://www.lexi.com
4. Austedo® UpToDate®. Walters Kluwer; Accessed January 2021. http://www.uptodate.com
5. Ingrezza® (valbenazine) [prescribing information]. San Diego, CA: Neurocrine Biosciences Inc.; April 2017
6. Suchowersky O. Huntington disease: Management. Up To Date. January 29,2021.

Original Approval Date	Original Effective Date	Policy Owner	Approved by
9/10/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
9/10/2020	P&T annual review. No changes recommended. 9.077 VMAT2 Inhibitors Policy retired, new policy created	1/1/2021	P&T Committee
02/11/2021	P&T annual review. Addition of exclusion criteria to the policy. Addition of Ingrezza and related criteria to the policy. Austedo criteria changes: Addition of tetrabenzine trial before the approval of Austedo for chorea diagnosis, addition of criteria that ensures Austedo will not be used concurrently with other VMAT 2 agents, addition of daily dosing limits for Austedo. Addition of criteria for tardive dyskinesia that dose of offending agent is at the lowest effective dose.	06/01/2021	P&T Committee

Next Review Date

February 2022

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over

these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.