Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Austedo
(deutetrabenazine)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Austedo 6mg ☐ Austedo 9mg ☐ Austedo 12mg
ICD10:
Other (please specify):

Dose and Quantity: Frequency of therapy: Duration of therapy:

Is this a new start or continuation of therapy with Austedo? ☐ new start ☐ continued therapy
(if continued therapy) Has your patient had a beneficial clinical response with Austedo treatment? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***If you wish to order this medication from Accredo Specialty Pharmacy, please call 1-866-759-1557 for an order form.*

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Huntington's disease (HD) ☐ Tardive dyskinesia (TD)
☐ other *(please specify)*:

Clinical Information:
****This request requires supportive documentation (genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

(if HD) Has the diagnosis been confirmed by genetic testing (for example, an expanded HTT CAG repeat sequence of at least 36)? ☐ Yes ☐ No
(if HD) Does your patient have chorea (involuntary movements)? ☐ Yes ☐ No
(if TD) Is Austedo being prescribed by, or in consultation with, neurologist or a psychiatrist? ☐ Yes ☐ No
(if TD) Has your patient been treated with a dopamine receptor blocking agent (for example, antipsychotics, metoclopramide, prochlorperazine)? ☐ Yes ☐ No

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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