AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Tetrabenazine	Page:	1 of 2
Effective Date:	8/19/2024	Last Review Date:	7/23/2024

Applies to:	☒Illinois	☒Florida Kids	☒Pennsylvania
	☐Virginia	☒New Jersey	☒Maryland

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for tetrabenazine under the patient's prescription drug benefit.

Description:

A. FDA-Approved Indication
Treatment of chorea associated with Huntington's disease

B. Compendial Uses
1. Tic disorders
2. Tardive dyskinesia
3. Hemiballismus
4. Chorea not associated with Huntington's disease

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

tetrabenazine

Policy/Guideline:

Documentation:
Submission of the following information is necessary to initiate the prior authorization review for initial requests:
A. Tardive dyskinesia: Chart notes or medical record documentation of clinical manifestations of disease.
B. Chorea associated with Huntington's disease: Chart notes or medical record documentation of characteristic motor examination features.

Criteria for Initial Approval:

A. Chorea associated with Huntington's disease
Authorization of 6 months may be granted for treatment of chorea associated with Huntington's disease when BOTH of the following criteria are met:
1. Member demonstrates characteristic motor examination features
2. Member meets ONE of the following conditions:
   i. Laboratory results indicate an expanded *HTT* CAG repeat sequence of at least 36
   ii. Member has a positive family history for Huntington's disease

B. Chorea not associated with Huntington's disease

Authorization of 6 months may be granted for treatment of chorea not associated with Huntington's disease.

C. Tic disorders
Authorization of 6 months may be granted for treatment of tic disorders.

D. Tardive dyskinesia
Authorization of 6 months may be granted for treatment of tardive dyskinesia when BOTH of the following criteria are met:

1. Member exhibits clinical manifestations of disease.
2. Member's tardive dyskinesia has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS]).

E. Hemiballismus
Authorization of 6 months may be granted for the treatment of hemiballismus.

Criteria for Continuation of Therapy:
Authorization of 12 months may be granted for members who are experiencing benefit from therapy as evidenced by disease stability or disease improvement.

Approval Duration and Quantity Restrictions:

Approval:

- Initial approval: 6 months
- Renewal approval: 12 months

Quantity Level Limit:

- tetrabenazine 12.5 mg tablet: 120 per 30 days
- tetrabenazine 25 mg tablet: 60 per 30 days

References:

1. Xenazine [package insert]. Deerfield, IL: Lundbeck Inc.; November 2019.
2. Tetrabenazine [package insert]. Weston, FL: Apotex Corp.; October 2021.
3. Micromedex® (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: http://www.micromedexsolutions.com. Accessed March 14, 2024.
4. AHFS DI (Adult and Pediatric). Lexicomp. Last updated March 11, 2024. Accessed March 14, 2024. http://online.lexi.com/lco
5. Guay DRP. Tetrabenazine, a monoamine-depleting drug used in the treatment of hyperkinetic movement disorders. *Am J Geriatr Pharmacother*. 2010;8:331-373.
6. Kenney C, Hunter C, Jankovic J. Long-term tolerability of tetrabenazine in the treatment of hyperkinetic movement disorders. Movement Disorders. 2007;22(2):193-7.
7. American Psychiatric Association. (2021). *Practice Guideline for the Treatment of Patients With Schizophrenia, third edition.* https://doi.org/10.1176/appi.books.9780890424841