UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1238-7
Program	Prior Authorization/Notification
Medication	Tetrabenazine (Xenazine®*)
P&T Approval Date	12/2017, 12/2018, 12/2019, 11/2020, 2/2022, 2/2023, 2/2024
Effective Date	5/1/2024

1. Background

Tetrabenazine is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of chorea associated with Huntington's disease.[1] Tetrabenazine is also recommended by the American Academy of Neurology and American Psychiatric Association for consideration in the management of patients with tardive dyskinesia .[2]

2. Coverage Criteria[a]:

A. Chorea associated with Huntington's disease

1. **Initial Authorization**

a. **Tetrabenazine** will be approved based on the following criterion:

(1) Diagnosis of chorea associated with Huntington's disease

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Documentation of positive clinical response to tetrabenazine therapy

Authorization will be issued for 12 months.

B. Tardive Dyskinesia

1. **Initial Authorization**

a. **Tetrabenazine** will be approved based on the following criterion:

(1) Diagnosis of tardive dyskinesia

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Documentation of positive clinical response to tetrabenazine therapy

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization

management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place
- *Xenazine brand tablets are typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

4. References:

1. Xenazine [package insert]. Deerfield, IL: Lundbeck; November 2019.
2. Bhidayasiri R, Fahn S, Weiner WJ, et al. Evidence-based guideline: Treatment of tardive syndromes: Report of the guidelines development subcommittee of the American Academy of Neurology. Neurology. 2013;81;463-469.
3. Keepers GA, Fochtmann LJ, Anzia JM, et al. The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia. Focus (Am Psychiatr Publ). 2020;18(4):493-497. doi:10.1176/appi.focus.18402

Program	Prior Authorization/Notification – Tetrabenazine (Xenazine)
Change Control	
12/2017	New program
12/2018	Annual review. No changes to clinical coverage criteria.
12/2019	Annual review. No changes to clinical coverage criteria.
11/2020	Annual review. Updated references.
2/2022	No changes to clinical coverage criteria.
2/2023	Annual review. Updated background and references.
2/2024	Annual review. No changes to clinical coverage criteria.