

New Hampshire Medicaid Fee-for-Service Program Huntington's Disease Criteria

Approval Date: August 7, 2020

Medications

Brand Names	Generic Names	Dosage
Austedo®	deutetrabenazine	6, 9, 12 mg
Xenazine®	tetrabenazine	12.5, 25 mg

Criteria for Approval

1. Patient is ≥ 18 years old; **AND**
2. Diagnosis of Huntington's Chorea (Austedo® may also be approved for Tardive dyskinesia diagnosis).

For Austedo® only:

1. For the treatment of Huntington's disease, trial and failure of tetrabenazine (generic).

Criteria for Denial

1. Diagnosis criteria not met; **OR**
2. Untreated or inadequately treated depression, active suicidal ideation; **OR**
3. Concurrent therapy with tetrabenazine or deutetrabenazine, riserpine, valbenazine or MAOIs;
OR
4. Pregnancy; **OR**
5. Hepatic impairment.

Length of Approval: One year

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	10/25/2010
Commissioner	Approval	02/10/2011
DUR Board	Revision	03/20/2017
Commissioner	Approval	06/08/2017
DUR Board	Revision	10/24/2017
Commissioner	Approval	12/05/2017
DUR Board	Revision	03/12/2019
Commissioner Designee	Approval	04/05/2019
DUR Board	Revision	06/30/2020
Commissioner Designee	Approval	08/07/2020