

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1238-9
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, 2/2025, 2/2026
Effective Date	5/1/2026

1. Background

Tetrabenazine is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of chorea associated with Huntington’s disease. 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. Coverage Criteria^a:

<p>A. <u>Chorea associated with Huntington’s disease</u></p> <p>1. <u>Initial Authorization</u></p> <p>a. Tetrabenazine will be approved based on the following criterion:</p> <p style="padding-left: 40px;">(1) Diagnosis of chorea associated with Huntington's disease</p> <p style="padding-left: 40px;">Authorization will be issued for 12 months.</p> <p>2. <u>Reauthorization</u></p> <p>a. Documentation of positive clinical response to tetrabenazine therapy</p> <p style="padding-left: 40px;">Authorization will be issued for 12 months.</p> <p>B. <u>Tardive Dyskinesia</u></p> <p>1. <u>Initial Authorization</u></p> <p>a. Tetrabenazine will be approved based on the following criterion:</p> <p style="padding-left: 40px;">(1) Diagnosis of tardive dyskinesia</p> <p style="padding-left: 40px;">Authorization will be issued for 12 months.</p> <p>2. <u>Reauthorization</u></p> <p>a. Documentation of positive clinical response to tetrabenazine therapy</p> <p style="padding-left: 40px;">Authorization will be issued for 12 months.</p>

^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.

*Xenazine brand tablets are typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

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

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. Bhidayasiri R, Jitkriksadakul O, Friedman JH, Fahn S. Updating the recommendations for treatment of tardive syndromes: A systematic review of new evidence and practical treatment algorithm. *J Neurol Sci*. 2018;389:67-75. doi:10.1016/j.jns.2018.02.010
4. Keepers GA, Fochtmann LJ, Anzia JM, et al. The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia. *Am J Psychiatry*. 2020;177(9):868-872. doi:10.1176/appi.ajp.2020.177901

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.
2/2025	Annual review. No changes to clinical coverage criteria.
2/2026	Annual review. Updated placement of footnote for exclusion statement for Xenazine brand tablets without change to intent. Updated references.