New Hampshire Medicaid Fee-for-Service Program
Movement Disorders Criteria

Approval Date: January 22, 2024

Medications

Brand Names	Generic Names	Dosage
Austedo®	deutetrabenazine	6, 9, and 12 mg
Austedo® XR	deutetrabenazine	6, 12, and 24 mg
Ingrezza®	valbenazine	40, 60, and 80 mg
Xenazine®	tetrabenazine	12.5 and 25 mg

Criteria for Approval for Huntington's disease

1. Patient is ≥ 18 years old; **AND**
2. Diagnosis of Huntington's Chorea.

Criteria for Approval for Tardive Dyskinesia

1. Patient is ≥ 18 years old; **AND**
2. Diagnosis of tardive dyskinesia.

Criteria for Approval for Tourette's syndrome

1. Diagnosis of Tourette's syndrome; **AND**
2. Trial and failure of or not a candidate for tetrabenazine (generic).

Criteria for Denial

1. Diagnosis criteria not met; **OR**
2. Concurrent therapy with tetrabenazine or deutetrabenazine, reserpine, valbenazine, or monoamine oxidase inhibitors (MAOIs); **OR**
3. Pregnancy

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
DUR Board	Revision	12/15/2020
Commissioner Designee	Approval	02/24/2021
DUR Board	Revision	06/02/2022
Commissioner Designee	Approval	07/12/2022
DUR Board	Revision	12/08/2023
Commissioner Designee	Approval	01/22/2024