SPECIALTY GUIDELINE MANAGEMENT

XENAZINE (tetrabenazine)
Tetrabenazine (generic)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
   Treatment of chorea associated with Huntington’s disease

B. Compendial Uses
   1. Chronic tics
   2. Tardive dyskinesia
   3. Hemiballismus
   4. Chorea not associated with Huntington’s disease

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

A. Chorea
   Authorization of 12 months may be granted for treatment of chorea.

B. Chronic tics
   Authorization of 12 months may be granted for treatment of chronic tics.

C. Tardive dyskinesia
   Authorization of 12 months may be granted for the treatment of tardive dyskinesia.

D. Hemiballismus
   Authorization of 12 months may be granted for the treatment of hemiballismus.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

2. DRUGDEX® System (electronic version). Truven Health Analytics, Greenwood Village, Colorado. Available at

Tetrabenazine-Xenazine SGM P2017