Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

Effective: June 9, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Austedo and Austedo XR (deutetrabenazine) is a vesicular monoamine transporter 2 inhibitor approved for the treatment of chorea associated with Huntington's disease and tardive dyskinesia in adults.

Ingrezza and Ingrezza Sprinkle (valbenazine) is a selective vesicular monoamine transporter 2 inhibitor indicated for the treatment of adults with tardive dyskinesia and chorea associated with Huntington's disease.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of a Vesicular Monoamine Transporter 2 (VMAT2) Inhibitor for patients when the following criteria are met:

Huntington's Disease

1. Documented diagnosis of chorea associated with Huntington's Disease

AND

2. Prescribing physician is a neurologist

Tardive Dyskinesia

1. Documented diagnosis of moderate to severe tardive dyskinesia

AND

2. Patient is 18 years of age or older

Limitations

- For a non-formulary medication request, please refer to the Pharmacy Medical Necessity Guidelines for Formulary Exceptions and submit a formulary exception request to the plan as indicated.

Codes

None

References

1. American College of Radiology (ACR): ACR Appropriateness Criteria, Movement Disorders and Neurodegenerative Diseases. 2019.
2. Anderson K, et al. Clinical Management of Neuro psychiatric Symptoms of Huntington Disease: Expert-Based Consensus Guidelines on Agitation, Anxiety, Apathy, Psychosis and Sleep Disorders. Journal of Huntington's Disease, vol. 7, no. 4, pp. 355-366, 2018
3. Armstrong, M. J., Miyasaki, J. M. Evidence-based guideline: Pharmacologic treatment of chorea in Huntington disease: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. August 2012;79(6):597–603.

4. Austedo (deutetrabenazine) [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; Feb 2023.
5. Bhidayasiri R, et al. Updating the recommendations for the treatment of tardive syndromes: A systemic review of new evidence and practical treatment algorithm. Journal of the Neurological Sciences. 2018 June; 389:67-75.
6. Caroff S, et al. A Modified Delphi Consensus Study of the Screening, Diagnosis, and Treatment of Tardive Dyskinesia. J Clin Psychiatry. 2020 Jan 28;81(2).
7. Austedo (deutetrabenazine) [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; February 2025.
8. Ingrezza and Ingrezza Sprinkle (valbenazine) [package insert]. San Diego, CA: Neurocrine Biosciences, Inc.; April 2026.

Approval And Revision History

September 2022: Reviewed by the Pharmacy & Therapeutics Committee.

1. July 11, 2023: Added Austedo XR to the Medical Necessity Guideline (effective August 1, 2023)
2. November 14, 2023: Added Ingrezza to the coverage criteria for Huntington's chorea based on the supplemental indication (eff 12/1/2023).
3. July 9, 2024: Added Ingrezza Sprinkle to the Medical Necessity Guideline (eff 8/1/24).
4. June 10, 2025: No changes (eff 6/10/25).
5. June 9, 2026: No changes to clinical criteria. Administrative update to remove CareLink from the Medical Necessity Guideline template.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.