Effective Date: 6/2018
Reviewed Date: 6/2019, 7/2020, 5/2021, 4/2022, 3/2023, 3/2024, 3/2025, 2/2026 Scope: Medicaid

Tetrabenazine

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 Indication
Treatment of chorea associated with Huntington's disease

B. Compendial Uses
1. Tic disorders
2. Tardive dyskinesia
3. Hemiballismus
4. Chorea not associated with Huntington's disease

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

A. Chorea associated with Huntington's disease
Authorization of 6 months may be granted for treatment of chorea associated with Huntington's disease when all of the following criteria are met:
1. Tetrabenazine is prescribed by or in consultation with a neurologist
2. Member demonstrates characteristic motor examination features
3. Member meets one of the following conditions:
    i. Laboratory results indicate an expanded *HTT* CAG repeat sequence of at least 36
    ii. Member has a positive family history for Huntington's disease

B. Chorea not associated with Huntington's disease
Authorization of 6 months may be granted for treatment of chorea not associated with Huntington's disease.

C. Tic disorders
Authorization of 6 months may be granted for treatment of tic disorders.

D. Tardive dyskinesia
Authorization of 6 months may be granted for the treatment of tardive dyskinesia when all of the following criteria are met:

1. Must be prescribed by or in consultation with a neurologist or psychiatrist.
2. Documented diagnosis of tardive dyskinesia secondary to a centrally acting dopamine receptor-blocking agent (DRBA).
3. Documentation that member exhibits clinical manifestations of tardive dyskinesia
4. The member's tardive dyskinesia has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS])

E. Hemiballismus

Authorization of 6 months may be granted for the treatment of hemiballismus.

III. CONTINUATION OF THERAPY

Tetrabenazine will continue to pay after the initial approval if there is at least one paid claim of at least a 28-day supply within the last 365 days for tetrabenazine or authorization of 6 months may be granted if the member has documentation of a positive clinical response as evidenced by improvement or stabilization.

IV. QUANTITY LIMIT

a. Tetrabenazine 12.5mg tablet: 8 tablets/day
b. Tetrabenazine 25mg: 4 tablets/day

V. REFERENCES

1. Tetrabenazine [package insert]. Weston, FL: Apotex Corp.; October 2021.
2. Micromedex® (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: http://www.micromedexsolutions.com. Accessed February 9, 2026.
3. Guay DR. Tetrabenazine, a monoamine-depleting drug used in the treatment of hyperkinetic movement disorders. *Am J Geriatr Pharmacother*. 2010; 8:331-373.
4. Kenney C, Hunter C, Jankovic J. Long-term tolerability of tetrabenazine in the treatment of hyperkinetic movement disorders. Movement Disorders. 2007; 22(2): 193-7.
5. American Psychiatric Association. (2021). Practice Guideline for the Treatment of Patients With Schizophrenia, third edition. https://doi.org/10.1176/appi.books.9780890424841