pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

INGREZZA (valbenazine) (non-preferred) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **VMAT2 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on the Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Ingrezza capsule (non-preferred) ☐Ingrezza _____		Strength:
Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx codes (*required*):	

ALL requests		
1. Do any of the following reasons for dose adjustment apply to the beneficiary? *Check all that apply.* ☐taking a strong 3A4 inhibitor (eg, protease inhibitor, azole antifungal) ☐hepatic impairment ☐taking a strong 2D6 inhibitor (eg, bupropion, fluoxetine, paroxetine)	☐Yes ☐No	*Submit documentation of dosing, complete medication list, and LFT results.*
2. Is the beneficiary taking a strong CYP3A4 inducer (eg, rifampin, carbamazepine, phenytoin, St. John's Wort)?	☐Yes ☐No	*Submit beneficiary's complete medication list.*

INITIAL requests		
1. Is the beneficiary being treated for a diagnosis of tardive dyskinesia (TD)?	☐Yes – *Submit documentation supporting beneficiary's diagnosis.* ☐No – *Submit medical literature documentation supporting the use of Ingrezza for the beneficiary's diagnosis.*	
2. Is Ingrezza being prescribed by or in consultation with a neurologist or psychiatrist?	☐Yes ☐No	*If prescriber is not a neurologist or psychiatrist, submit documentation of consultation with a neurologist or psychiatrist.*
3. Does the beneficiary have a history of trial and failure of, or contraindication or intolerance to, the preferred medication in this class, **Xenazine**?	☐Yes ☐No	*Submit documentation.*
4. Did the beneficiary have a mental health evaluation?	☐Yes ☐No	*Submit documentation of evaluation.*
5. ***If the beneficiary has a history of prior suicide attempt,violent behavior, bipolar disorder, or major depressive disorder***, was the beneficiary evaluated in the past 6 months and treated by a psychiatrist?	☐Yes ☐No	*Submit documentation of evaluation and treatment.*
6. ***For the treatment of tardive dyskinesia,*** *submit documentation of the following* as it applies to the beneficiary*:* ☐has no other causes of involuntary movement ☐a dose decrease of dopamine receptor blocking agents is not appropriate ☐has documentation of TD severity ☐other therapies for TD are not appropriate		

RENEWAL requests		
1. Since starting Ingrezza, did the beneficiary experience an improvement in the medical condition being treated?	☐Yes ☐No	*Submit documentation of beneficiary's response to therapy.*
2. Was the beneficiary reevaluated (and treated, if applicable) for new onset or worsening symptoms of depression and determined to be a candidate for treatment with Ingrezza?	☐Yes ☐No	*Submit documentation of evaluation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: