

### INGREZZA (valbenazine) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **VMAT2 Inhibitors** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages: _____		Prescriber name:	
Name of office contact:				Specialty:	
Contact's phone number:				NPI:	
LTC facility contact/phone:				State license #:	
Beneficiary name:				Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:		Fax:

#### CLINICAL INFORMATION

<b>Medication requested:</b>		<input type="checkbox"/> Ingrezza capsule <input type="checkbox"/> Ingrezza _____ <input type="checkbox"/> Ingrezza initiation pack		Strength:	
Dose/directions:			Quantity:		Refills:
Diagnosis ( <i>submit documentation</i> ):				Dx codes ( <i>required</i> ):	

#### ALL requests

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

#### INITIAL requests

Is the beneficiary being treated for a diagnosis of tardive dyskinesia (TD)?		<input type="checkbox"/> Yes – <i>Submit documentation supporting beneficiary's diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature documentation supporting the use of Ingrezza for the beneficiary's diagnosis.</i>	
Is Ingrezza being prescribed by or in consultation with a neurologist or psychiatrist?		<input type="checkbox"/> Yes <i>If prescriber is not a neurologist or psychiatrist, submit documentation of consultation with a neurologist or psychiatrist.</i> <input type="checkbox"/> No	
Did the beneficiary have a mental health evaluation?		<input type="checkbox"/> Yes <i>Submit documentation of evaluation.</i> <input type="checkbox"/> No	
<b><i>If the beneficiary has a history of prior suicide attempt, violent behavior, bipolar disorder, or major depressive disorder,</i></b> was the beneficiary evaluated in the past 6 months and treated by a psychiatrist?		<input type="checkbox"/> Yes <i>Submit documentation of evaluation and treatment.</i> <input type="checkbox"/> No	

***For the treatment of tardive dyskinesia, submit documentation of the following as it applies to the beneficiary:***

- |  |  |
|--|--|
| <input type="checkbox"/> has no other causes of involuntary movement | <input type="checkbox"/> a dose decrease of dopamine receptor blocking agents is not appropriate |
| <input type="checkbox"/> has documentation of TD severity            | <input type="checkbox"/> other therapies for TD are not appropriate                              |

#### RENEWAL requests

Since starting Ingrezza, did the beneficiary experience an improvement in the medical condition being treated?		<input type="checkbox"/> Yes <i>Submit documentation of beneficiary's response to therapy.</i> <input type="checkbox"/> No	
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?		<input type="checkbox"/> Yes <i>Submit documentation of evaluation.</i> <input type="checkbox"/> No	

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

<b>Prescriber Signature:</b>		<b>Date:</b>	
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