

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Commercial Commercial Individual (PPACA) Medicaid
 This request is: Urgent (life threatening) Non-Urgent (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Ingrezza[®] (valbenazine)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
 Provider Address: _____
 Provider NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

Product Information

New request Continuation request

Drug product: Ingrezza 40mg Capsule Ingrezza 80mg Capsule
 Start date (or date of next dose): _____
 Date of last dose (if applicable): _____
 Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for each Ingrezza 80 mg capsule is \$207.50. The annual cost of treatment with this drug will be greater than \$74,000.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Be at least 18 years old
2. Diagnosis of antipsychotic or dopamine receptor blocker-induced tardive dyskinesia (TD), or a GI disorder with metoclopramide induced tardive dyskinesia (TD) lasting for at least 3 months.
3. Have moderate or severe TD, which is indicated by a score of 3 or 4 on item 8 (severity of abnormal movements overall) of the Abnormal Involuntary Movement Scale (AIMS).
4. Documentation of the member's current AIMS score from items 1-7 (available on this form)
5. Not be at significant risk for suicidal or violent behavior and does not have unstable psychiatric symptoms.
6. Have tried and failed non-pharmacologic intervention including:
 - a. Discontinuing the offending agent

For continuation, patient must have met the following requirements:

1. Documentation of a decreased AIMS score (items 1 to 7) from baseline must be submitted to Priority Health (documentation must be submitted to Priority Health).

Additional information

Note: Initial approval is limited to 2 months, approvals for continuation being limited to one year.

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

New request
Priority Health Precertification Documentation

- A. What condition is this drug being requested for?**
- a. Tardive Dyskinesia (antipsychotic, dopamine receptor blocker, or metoclopramide-induced)
 - b. Other – the patient's condition is: _____
 - c. Rationale for use: _____
- B. Does the patient have moderate or severe TD, which is indicated by a score of 3 or 4 on item 8 (severity of abnormal movements overall) of the Abnormal Involuntary Movement Scale (AIMS).**
- a. Yes
 - b. No; rationale: _____
- C. What is the patient's current AIMS score for items 1-7? _____** (documentation must be submitted to Priority Health)
- D. Is the member suicidal, have violent behaviors, or other unstable psychiatric symptoms?**
- a. No
 - b. Yes; rationale: _____
- E. What non-pharmacologic interventions has the patient tried?**
- _____
- _____
- _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

- A. Did the patient's AIMS score for items 1-7 decrease?**
- a. No
 - b. Yes
- New AIMS score: _____

Abnormal involuntary movement scale

Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration
National Institute of Mental Health

KEY: 0 = None
1 = Minimal, may be extreme normal
2 = Mild
3 = Moderate
4 = Severe

NAME: _____

DATE: _____

Prescribing practitioner: _____

MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. Circle movement as well as code number that applies.		RATER
		Date
Facial and oral movements	1. Muscles of facial expression eg, movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	0 1 2 3 4
	2. Lips and perioral area eg, puckering, pouting, smacking	0 1 2 3 4
	3. Jaw eg, biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4
	4. Tongue Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth.	0 1 2 3 4
Extremity movements	5. Upper (arms, wrists, hands, fingers) Include choreic movements (ie, rapid, objectively purposeless, irregular, spontaneous) athetoid movements (ie, slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (ie, repetitive, regular, rhythmic).	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes) eg, lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4
Trunk movements	7. Neck, shoulders, hips eg, rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4
Global judgments	8. Severity of abnormal movements overall	0 1 2 3 4
	9. Incapacitation due to abnormal movements	0 1 2 3 4
	10. Patient's awareness of abnormal movements Rate only patient's report - No awareness 0 - Aware, no distress 1 - Aware, mild distress 2 - Aware, moderate distress 3 - Aware, severe distress 4	0 1 2 3 4
Dental status	11. Current problems with teeth and/or dentures?	No Yes
	12. Are dentures usually worn?	No Yes
	13. Edentia?	No Yes
	14. Do movements disappear in sleep?	No Yes