PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **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).

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2017

Last reviewed 01/2019

Additional information

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

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used 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: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2017
Last reviewed 01/2019

PriorityHealth

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

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2017
Last reviewed 01/2019