Montana Healthcare Programs Prior Authorization Request Form for Use of Ingrezza® (valbenazine)

Member Name: ____________________________ DOB: ____________ Date: ____________

Member ID: ____________________________ Prescriber Phone: ____________________________

Prescriber Name/Specialty if applicable: ____________________________ Prescriber Fax: ____________________________

Please complete below information for applicable situation, Initiation or Continuation of therapy and attach supporting documentation:

☐ INITIATION OF THERAPY

1. Last 6 months of chart notes are attached (required): ☐ Yes ☐ No
2. Medication is prescribed by, or in consult with (physically seen by) ☐ Psychiatrist ☐ Neurologist ☐ Psychiatric NP (PMHNP)
3. Member must be ≥18 years of age: ☐ Yes ☐ No
4. Member has a diagnosis of moderate to severe tardive dyskinesia (TD) ☐ Yes ☐ No
5. TD must be antipsychotic (dopamine receptor blocker) induced ☐ Yes ☐ No
6. Provider attests that they have ruled out other potential causes of movement disorder, including but not limited to, stimulants, stimulant use disorder, metoclopramide, etc.: ☐ Yes ☐ No
7. Symptoms have been present for at least 2 months prior to prescribing ☐ Yes ☐ No
8. Provide documented baseline evaluation of the condition using the Abnormal Involuntary Movement Scale (AIMS) with a minimum score of >6 using items 1-7 (categories I, II, III). AIMS Score (attach): ____________
9. TD symptoms have improved evidenced by improved AIMS score AND increased function, quality of life, or socialization (chart notes must be attached).

☐ CONTINUATION OF THERAPY

☐ TD symptoms have improved evidenced by improved AIMS score AND increased function, quality of life, or socialization (chart notes must be attached).

LIMITATIONS: Max allowed 30 capsules per 30 days of the 80 mg strength or 30 capsules per 30 days of the 40 mg strength. Initial authorization will be issued for 12 weeks.

Reauthorization will be issued for 6 months.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit @ 1-800-294-1350

02/2023