

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

Huntington's Chorea

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a functional disability resulting from chorea associated with Huntington's disease, confirmed by a neurologist: ☐ Yes ☐ No
3. Provider attests they are aware of boxed warning of increased risk of depression and suicidal ideation and behavior in patients with Huntington's disease: ☐ Yes ☐ No
4. Provider attests member is not at significant risk of suicidal behavior: ☐ Yes ☐ No
5. Provider attests member will be counseled on and monitored for depression and suicidal thoughts and behaviors: ☐ Yes ☐ No
6. Provider attests member will not concomitantly be on a monoamine oxidase inhibitor (MAOI) or reserpine: ☐ Yes ☐ No
7. Provider attests member will not use Ingrezza® concomitantly with any other vesicular monoamine transporter 2 (VMAT2) inhibitors: ☐ Yes ☐ No
8. If medication is nonpreferred (please refer to the Montana Medicaid Preferred Drug List for current preferred options), member has had an inadequate response, contraindication or intolerance to a **preferred** therapeutic alternative: ☐ Yes ☐ No ☐ N/A – Drug is preferred.

Drug name: _____ Date used: _____

Reason for discontinuation: _____

LIMITATIONS:

Maximum quantity allowed: one (1) capsule per day of either 40mg or 80mg strength.

Initial authorization will be issued for 6 months.

Tardive Dyskinesia

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of moderate to severe tardive dyskinesia (TD): ☐ Yes ☐ No
3. Medication is prescribed by or in consult with (physically seen by): ☐ Psychiatrist ☐ Neurologist
☐ Psychiatric NP (PMHNP)
4. Symptoms have been present for at least 2 months prior to prescribing: ☐ Yes ☐ No
5. Last 6 months of chart notes are attached (required): ☐ Yes ☐ No
6. TD must be antipsychotic (dopamine receptor blocker) induced: ☐ Yes ☐ No
7. Provider attests they have ruled out other potential causes of movement disorder, including but not limited to stimulants, stimulant use disorder, metoclopramide, etc.: ☐ 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. Member's TD interferes with the member's functional status, including self-care and ambulation, quality of life or creates a social stigma sufficient to cause social isolation or embarrassment: ☐ Yes ☐ No
10. Prescriber has documented the specific movement(s) in the member's medical record along with how TD is affecting the member's function, quality of life or socialization: ☐ Yes ☐ No
11. Member has had an inadequate response to the following treatment modalities, unless all are contraindicated, not tolerated or are inappropriate to maintain stable psychiatric function:
☐ Discontinuation or dose modification of the offending medication
☐ Switching from a first-generation antipsychotic to a second-generation antipsychotic
12. Provider attests member is not currently and will not be prescribed any MAOI or reserpine: ☐ Yes ☐ No
13. Provider attests member will not use Ingrezza® concomitantly with any other vesicular monoamine transporter 2 (VMAT2) inhibitors: ☐ Yes ☐ No
14. If medication is nonpreferred (please refer to the Montana Medicaid Preferred Drug List for current preferred options), member has had an inadequate response, contraindication or intolerance to a **preferred** therapeutic alternative: ☐ Yes ☐ No ☐ N/A – Drug is preferred.

Drug name: _____ Date used: _____

Reason for discontinuation: _____

LIMITATIONS:

Maximum quantity allowed: one (1) capsule per day of either 40mg or 80mg strength.

Initial authorization will be issued for 12 weeks.

☐ CONTINUATION OF THERAPY

Huntington's Chorea

1. Member has shown symptom improvement as evidenced by a decrease in the Total Maximal Chorea Score:
☐ Yes ☐ No
2. Member is not at significant risk for suicidal behavior: ☐ Yes ☐ No

Tardive Dyskinesia

1. Tardive Dyskinesia symptoms have improved as evidenced by improved AIMS score AND increased function, quality of life or socialization (*chart notes must be attached*): ☐ Yes ☐ No
2. Chart notes from the last 6 months are attached: ☐ Yes ☐ No

LIMITATIONS:

Maximum quantity allowed: one (1) capsule per day of either 40mg or 80mg strength.

Reauthorization will be issued for 6 months.

**Please complete form, including required attachments, and fax to
Drug Prior Authorization Unit at 1-800-294-1350.**

10/2023