Maryland Medicaid Pharmacy Program
Fax: (410) 333-5398
Phone: (800) 492-5231- Option 3

Ingrezza® Prior Authorization Form
Incomplete forms will not be reviewed

Maryland
DEPARTMENT OF HEALTH

Date: _____

Patient Information:

Name: DOB:

MA#: Sex: ☐ **M** ☐ **F**

Prescriber Information:

Name: NPI #:

Phone #: Fax #:

Contact Person for this PA Request:

Name: Phone: Fax:

This request is for (choose one): ☐Ingrezza Initial Pack ☐Ingrezza 40 mg ☐Ingrezza 60 mg ☐Ingrezza 80 mg capsule
Quantity Limit: One capsule per day for any strength

☐Initial PA Request ☐Renewal PA Request

Initial approval is for ninety (90) days and renewal approval is for one (1) year. Most recent Progress Note and AIM Score sheet are required to submit along with this PA form for both initial and renewal requests.

Approval is granted when all five (5) criteria below are met for both initial and renewal requests:

☐ The patient is at least 18 Years of Age

☐ The patient's diagnosis is Tardive Dyskinesia as defined by DSM-5

☐ Treatment history with Antipsychotic or other Dopamine Blocking Agent for at least ninety (90) days

☐ The patient is NOT receiving other VMAT2 inhibitors or MAOI

☐AIM Score Provided Initial AIM Score:_____ Renewal Request AIM Score:_____

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature:_____ **Date:**_____