Office of Pharmacy Services
Fax (410) 333-5398
Tel: (800) 492-5231 opt. # 3

Ingrezza CC
Prior Authorization Form

Maryland
DEPARTMENT OF HEALTH

Patient's Information: **Date:** _____

Name: _____ DOB: _____

Participant's Maryland Medicaid Number: _____

Prescriber's Information:

Name: _____ NPI #: _____

Phone #: _____ Fax #: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

INGREZZA CC:

Approval is granted if all 5 criteria in the table below are met. If met, approval given for 90 days. After 90 days, all 5 criteria must again be met, but AIMS* must show an improvement over the initial score— approval for 12 months.

This request is for:

☐ **Ingrezza 40 mg caps** ☐ **Ingrezza 80 mg caps**

☐ **Initial** PA Request (90 days approval if criteria met)

☐ **Renewal** PA Request (12 month approval if criteria met)

Criteria for Both Initial and Renewal PA Approval:

☐	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 90 days		
☐	The patient is NOT receiving other VMAT2 inhibitors or MAOIs		
☐	AIMS score provided*	Initial AIMS score _____	Renewal Request AIMS score _____

***The AIMS score must be provided for both the initial and renewal PA request; to continue therapy for 12 months, improvement in AIMS is required. (Supporting Clinical Documentation is required.)**

Quantity for Ingrezza 40 mg and 80 mg capsules is limited to 1 cap/day.

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.

Prescriber's Signature _____ Date _____

Fax this completed form to : (410) 333-5398, once all the required information has been provided. **Incomplete forms will not be reviewed**.

September 2020