Ingrezza® (valbenazine) Prior Authorization Form

Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (410) 333-5398
Phone: (833) 325-0105

Date: _____

Patient Information

Name: _____ DOB: _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Diagnosis: ❑ Tardive dyskinesia (TD) ❑ Chorea associated with Huntington's disease (HD) ❑ Other: _____

Prescription Information

❑ Initial PA Request ❑ Renewal PA Request

Strength: ❑ Ingrezza initial pack ❑ Ingrezza capsule(s) _____ mg

Instruction: _____

Initial approval is for 90 days and renewal approval is for one year

Following criteria must be met and documents be submitted to review for both initial and renewal requests

❑ Age ≥ 18 years

❑ Most recent progress notes

❑ Patient is NOT on other VMAT2 inhibitors or MAOI

TD specific criteria:

❑ Diagnosis of TD as defined by DSM-5

❑ AIMS score sheet ❑ Initial score _____ ❑ Renewal score _____

HD specific criteria

❑ Total Maximal Chorea (TMC) score sheet ❑ Initial score _____ ❑ Renewal score _____

I attest that

❑ Patient's lab/test results and clinical data will be evaluated and monitored.

❑ The requested medication is not part of a clinical trial and that the benefits of the treatment 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_____