AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Ingrezza™ (valbenazine)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval: 6 months

- ❑ Medication is prescribed by a neurologist or psychiatrist
- ❑ Member is ≥ 18 years of age
- ❑ Member has a diagnosis of moderate to severe tardive dyskinesia as confirmed by a neurologist or psychistrist and has met all DSM-5 diagnostic criteria **(chart notes documenting ALL criteria MUST be attached)**
  - ❑ Member has involuntary athetoid or choreiform movements
  - ❑ Member has history of treatment with dopamine receptor blocking agent (DRBA) **(claims history or chart notes must be attached)**
  - ❑ Symptom duration has lasted more than 4 to 8 weeks

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- ❑ AIMS assessment must be completed to obtain baseline evaluation **(completed AIMS assessment must be attached to document moderate to severe symptoms)**
- ❑ One of the following exists **(chart notes documenting ALL criteria MUST be attached)**:
  - ❑ Member has persistent symptoms of tardive dyskinesia despite a trial dose reduction, tapering, or discontinuation of the offending agent or switch to alternative therapy, such as atypical antipsychotic medication **OR**
  - ❑ Member is not a candidate for a trial dose reduction, tapering, or discontinuation of the offending agent
- ❑ Patient will NOT take Ingrezza™ concurrently with Austedo (deutetrabenazine) or Xenaxine (tetrabenazine)

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Documentation of positive clinical response to Ingrezza™ therapy **(chart notes MUST be attached)**
- ❑ Improvement in current AIMS score compared to baseline submission **(current completed AIMS assessment must be attached)**

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee**: 8/17/2017
REVISED/UPDATED: ~~9/27/2017~~; ~~5/3/2018~~; ~~2/1/2019~~; ~~6/12/2020~~;~~10/11/2021~~; **10/27/2023**;