Prior Authorization Request Form for
valbenazine (Ingrezza)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a neurologist or psychiatrist?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Ingrezza*	☐ Yes (subject to verification) proceed to question **11**	☐ No proceed to question **4**
4. Does the patient have suicidal ideation?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **5**
5. Does the patient have depression?	☐ Yes proceed to question **6**	☐ No proceed to question **7**
6. Is the patient being adequately treated for depression?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have moderate to severe tardive dyskinesia causing functional impairment along with schizophrenia, schizoaffective disorder, or a mood disorder?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for valbenazine (Ingrezza)

8. Has the provider considered a dose reduction, tapering, or discontinuation of the dopamine receptor blocking agent suspected of causing the symptoms?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have congenital or acquired long QT syndrome or arrhythmias associated with QT prolongation?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. Is the patient taking any of the following: • **MAOI inhibitor** • **another VMAT2 inhibitor (for example: tetrabenazine, deutetrabenazine)** • **CYP3A4 inducers** • **CYP3A4 inhibitors** • **CYP2D6 inducers**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
11. Has the patient demonstrated improvement in symptoms based on an improvement of at least 2 on the Abnormal Involuntary Movement Scale (AIMS)?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient being monitored for depression and suicidal ideation?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[31 July 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: