Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Ingrezza TM (valbenazine)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is Ingrezza being prescribed by a neurologist, psychiatrist, or a movement disorder specialist provided the patient has reasonable access?
☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q3. Are chart notes confirming that the patient has a diagnosis of tardive dyskinesia attached? (Please attach the details of the patient's symptoms including when symptoms first began)
☐ Yes ☐ No

Q4. Is Ingrezza being requested for other movement disorders that are not tardive dyskinesia (such as Huntington's Chorea, Parkinson's Disease)? (Please attach medical records including an evaluation to rule out other diagnoses (such as Huntington's Chorea, Parkinson's Disease)
☐ Yes ☐ No

Q5. Has documentation of the patient's recent Abnormal Involuntary Movement Scale (AIMS) been attached? (Please attach documentation of the patient's recent AIMS.)
☐ Yes ☐ No

Q6. Has documentation of the patient's baseline Abnormal Involuntary Movement Scale (AIMS) been attached to compare to the recent AIMS, in order to attribute the patient's tardive dyskinesia diagnosis to the use of a dopamine-receptor blocking agent(s)? (Please attach documentation of the patient's baseline AIMS.)
☐ Yes ☐ No

Q7. Has documentation been attached, or is claims history present, showing that the patient has current or former chronic use of a dopamine-receptor blocking agent(s)?

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☐ Yes ☐ No

Q8. Has documentation been attached indicating that dose reduction of the dopamine-receptor blocking agent(s), gradual discontinuation of the dopamine-receptor blocking agent(s), or switching from a typical to an atypical dopamine-receptor blocking agent(s) is not an option?

☐ Yes ☐ No

Q9. Has the patient tried alternative medications (including amantadine, trihexyphenidyl, benztropine) if applicable? Please attach medical records confirming the reason why alternative medications (including amantadine, trihexyphenidyl, benztropine) cannot be tried or documentation of medication(s) tried, with dose, dates/duration of use, and specific outcomes.)

☐ Yes ☐ No

Q10. Is the patient currently taking a Monoamine Oxidase Inhibitor (such as isocarboxazid, phenelzine, selegiline) or a strong CYP3A4 inducer (such as rifampin, carbamazepine, phenytoin, St. John's wort)?

☐ Yes ☐ No

Q11. Does the patient have congenital QT syndrome or arrhythmias associated with a prolonged QT interval?

☐ Yes ☐ No

Q12. Requested Duration:

☐ 3 Months ☐ Other:___

Prescriber Signature

Date

Updated 2017