



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Ingrezza TM (valbenazine) Renewal

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.

Form with two columns: Patient Name and Prescriber Name. Fields include HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and Specialty/facility name (if applicable).

Expedited/Urgent checkbox

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. Has the patient been previously approved for Ingrezza?

Yes/No checkboxes

Q2. Has the patient been compliant with receiving Ingrezza?

Yes/No checkboxes

Q3. Has documentation of improvement in tardive dyskinesia symptoms as evidenced by a reduction in the updated AIMS score after treatment with Ingrezza, compared to the AIMS score prior to treatment with Ingrezza, been attached? (Please attach an updated AIMS score that was completed after Ingrezza was started.)

Yes/No checkboxes

Q4. Has the patient been tolerating Ingrezza without any significant side effects?

Yes/No checkboxes

Q5. 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 checkboxes

Q6. Does the patient have congenital QT syndrome or arrhythmias associated with a prolonged QT interval?

Yes/No checkboxes

Q7. Requested Duration:

6 Months/Other checkboxes

Prescriber Signature

Date

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Updated 2017