OPTIMA HEALTH PLAN

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 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Ingrezza™** (valbenazine)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA*: *ALL information below MUST be checked to qualify or authorization process will be delayed. Chart note, lab results, and/or any testing/score MUST be submitted with this request.

Initial Approval – Length is for 3 months.

- **Prescriber is:** ❑ **Neurologist** ❑ **Psychiatrist**
  - ❑ Patient is ≥ 18 years of age
  - ❑ Patient has a diagnosis of moderate to severe tardive dyskinesia, meeting all DSM-5 diagnostic criteria
    - ❑ Involuntary athetoid or choreiform movements
    - ❑ 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
    - ❑ Documentation that AIMS test has been completed to obtain baseline evaluation ***(testing or score must be attached).*** One of the following:
      - ❑ Patient has persistence symptoms of tardive dyskinesia despite a trail dose reduction, tapering, or discontinuation of the offending agent
      - ❑ Patient is not a candidate for a trial dose reduction, tapering, or discontinuation of the offending agent

Reauthorization Approval – Length is for 12 months

***Requests must include all of the following information*:**

- ❑ Documentation of positive clinical response to Ingrezza™ therapy
- ❑ Improvement in current AIMS score compared to baseline submission ***(testing or score must be attached)***

(signature on next page)

Medication being provided by (check applicable box below):

- ❑ **Physician's office**

OR

- ❑ **Specialty Pharmacy:** ❑ **Briova SpecialtyRx**

*****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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 8/17/2017
REVISED/UPDATED: 9/27/2017