

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 \geq 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 trial 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:

PropriumRx

****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