OPTUMRx®

Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Optima Health

Ingrezza® Prior Authorization Request Form

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Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate-to-severe tardive dyskinesia

❑ Other diagnosis: ______________________________ ICD-10 Code(s): ______________________________

Clinical information:

Is the prescriber a neurologist or psychiatrist? ❑ **Yes** ❑ **No**

Does the patient have involuntary athetoid or choreiform movements? ❑ **Yes** ❑ **No**

Does the patient have a history of treatment with dopamine receptor blocking agent (DRBA)? ❑ **Yes** ❑ **No**

Claims history or chart notes must be provided

Did the patient have symptoms that lasted more than 4 to 8 weeks? ❑ **Yes** ❑ **No**

Is there documentation that an AIMS test has been completed to obtain baseline evaluation? ❑ **Yes** ❑ **No**

If **yes**, answer the following questions:

Has the patient had persistent symptoms of tardive dyskinesia despite a trail dose reduction, tapering, or discontinuation of the offending agent? ❑ **Yes** ❑ **No**

Is the patient a candidate for a trial dose reduction, tapering, or discontinuation of the offending agent? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to Ingrezza therapy? ❑ **Yes** ❑ **No**

Is there improvement in current AIMS score compared to baseline submission? ❑ **Yes** ❑ **No**

Testing or score must be provided

Medication being provided by: (Please check applicable box below)

❑ Physician's office ❑ PropriumRx ❑ Specialty Pharmacy (specify name): ______________________

****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.

Prescriber Signature: ______________________________ **Date:** ______________________________

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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