US Family Health Plan
Prior Authorization Request Form for
valbenazine (**Ingrezza**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial review expires after 1 year, continuation therapy is indefinite. For renewal of therapy an initial TRICARE/US Family Health Plan prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
	_____		_____
Sponsor ID #	_____	Phone #:	_____
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with a neurologist or psychiatrist?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Ingrezza*	☐ Yes (subject to verification) proceed to question **11**	☐ No proceed to question **4**
4. Does the patient have suicidal ideation?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **5**
5. Does the patient have depression?	☐ Yes proceed to question **6**	☐ No proceed to question **7**
6. Is the patient being adequately treated for depression?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have moderate to severe tardive dyskinesia causing functional impairment along with schizophrenia, schizoaffective disorder, or a mood disorder?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Has the provider considered a dose reduction, tapering, or discontinuation of the dopamine receptor blocking agent suspected of causing the symptoms?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have congenital or acquired long QT syndrome or arrhythmias associated with QT prolongation?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. Is the patient taking any of the following: • **MAOI inhibitor** • **another VMAT2 inhibitor (for example: tetrabenazine, deutetrabenazine)** • **CYP3A4 inducers** • **CYP3A4 inhibitors** • **CYP2D6 inducers**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
11. Has the patient demonstrated improvement in symptoms based on an improvement of at least 2 on the Abnormal Involuntary Movement Scale (AIMS)?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient being monitored for depression and suicidal ideation?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date