Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Ingrezza - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

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. Is this a request for continuation of therapy with Ingrezza?

☐ Yes ☐ No

Q2. Has the patient been approved for treatment with Ingrezza?

☐ Yes ☐ No

Q3. Does the patient have a documented improvement in symptoms related to tardive dyskinesia with an updated Abnormal Involuntary Movement Scale (AIMS) assessment attached?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is Ingrezza being requested by or in consultation with a neurologist or psychiatrist?

☐ Yes ☐ No

Q6. Has the patient been diagnosed with tardive dyskinesia and has a copy of the Abnormal Involuntary Movement Scale (AIMS) assessment been attached?

☐ Yes ☐ No

Q7. Is there documentation that other movement disorders (such as Parkinson's disease, chorea associated with Huntington's disease) have been excluded?

☐ Yes ☐ No

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Ingrezza - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Patient Name:	**Prescriber Name:**

Q8. Does the patient have documentation of current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine)? Please attach documentation.

☐ Yes ☐ No

Q9. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged QT interval, pregnancy) been excluded?

☐ Yes ☐ No

Q10. Will Ingrezza be used concurrently with either a monoamine oxidase (MAO) inhibitor or strong cytochrome 3A4 (CYP3A4) inducer?

☐ Yes ☐ No

Q11. Additional Information:

Q12. Requested Duration:

☐ 12 Months

Prescriber Signature

Date

2022 Medicare Prior Authorization Request