



# Movement Disorder Agents (Ingrezza)

## – Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.  
**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**  
**Allow at least 24 hours for review.**

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	Qty/Days supply

1. Is this request for a continuation of therapy?  Yes  No  
 If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response (e.g, reduction in involuntary movements, decrease in total maximal chorea score, or improvement in AIMS or CGI-TD score)?  
 Yes  No
  
2. Indicate patient's diagnosis:  
 Chorea associated with Huntington's disease  
 Tardive dyskinesia  
 Other. Specify: \_\_\_\_\_
  
3. Is this being prescribed by or in consultation with a health care provider with experience treating individuals with serious mental illness?  Yes  No
  
4. Has a baseline assessment been completed using any of the following? Check all that apply:  
 The Unified Huntington's Disease Rating Scale (UHDRS). Specify section completed:  
 Motor  
 Cognitive  
 Behavioral  
 Functional Assessment  
 Independence Scale  
 Total Functional Capacity  
 Abnormal Involuntary Movement Scale (AIMS)  
 Clinical Global Impression of Change – Tardive Dyskinesia (CGI-TD)
  
5. Will this be used in combination with a monoamine oxidase inhibitor (MAOI) [e.g. isocarboxazid, phenelzine, tranylcypromine, reserpine] or another vesicular monoamine transporter 2 (VMAT2) inhibitor [e.g. tetrabenazine]?  Yes  No
  
6. Has patient had treatment (minimum of 12 weeks) with deutetrabenazine or deutetrabenazine ER that has been ineffective, not tolerated, or is treatment contraindicated?  Yes  No

7. What alternative treatments has patient tried?  
What was the outcome of the trial?

**If patient has tardive dyskinesia:**

8. Does patient continue to experience persistent TD after trying one of the following unless contraindicated, not tolerated, or put patient's psychiatric stability at risk?
- Switching from a 1<sup>st</sup> generation to a 2<sup>nd</sup> generation antipsychotic
  - Patient has tried two 2<sup>nd</sup> generation antipsychotics
  - Patient has a history of discontinuation or dose modification of the offending medication with continued symptoms

**Chart notes, labs and all diagnostic tests confirming diagnosis are required with this request**

Prescriber signature

Prescriber specialty

Date