carolina complete health™

Pharmacy Prior Approval Request for
Movement Disorders: Ingrezza

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ___

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days
Continuation Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Does the member have a diagnosis of moderate to severe Tardive Dyskinesia? ☐ **Yes** ☐ **No**
2. Is the member age 18 or older? ☐ **Yes** ☐ **No**
3. Has the provider completed baseline evaluations of the condition using either Abnormal Involuntary Movement Scale (AIMS) or Extrapyramidal Symptom Rating Scale (ESRI) along with this request? ☐ **Yes** ☐ **No**
   3b. Please include **AIMS score**: _____ or **ESRI score:** _____
4. Has the member had a previous trial of an alternative method to manage the condition? ☐ **Yes** ☐ **No**
5. Is the member receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ **Yes** ☐ **No**
6. Is the member concurrently using a MAOI (Monoamine Oxidase Inhibitor) or reserpine? ☐ **Yes** ☐ **No**

For Continuation of Therapy, answer questions 1-6 and attach documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/