UnitedHealthcare Community Plan

NC 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 beneficiary have a diagnosis of moderate to severe Tardive Dyskinesia? ☐ **Yes** ☐ **No**
2. Is the beneficiary age 18 or older? ☐ **Yes** ☐ **No**
3. Has the provider submitted documented baseline evaluations of the condition using either Abnormal Involuntary Movement Scale(AIMS) or Extrapyramidal Symptom Rating Scale (ESRI) along with this request? ☐ **Yes** ☐ **No**
4. Has the beneficiary had a previous trial of an alternative method to manage the condition? ☐ **Yes** ☐ **No**
5. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ **Yes** ☐ **No**
6. Is the beneficiary concurrently using a MAOI (monoamine oxidase inhibitor) or reserpine? ☐ **Yes** ☐ **No**

For Continuation of Therapy, 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 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593