UnitedHealthcare Community Plan

Ingrezza - Pennsylvania
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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

UnitedHealthcare Community Plan

Ingrezza - Pennsylvania
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ Yes □ No	**Does the patient have a diagnosis of tardive dyskinesia?**
□ Yes □ No	**Is Ingrezza prescribed by or in consultation with a neurologist or a psychiatrist?**
□ Yes □ No	**Does the patient have a contraindication to Ingrezza?**
□ Yes □ No	**Does the patient have a history of prior suicide attempt, bipolar disorder, or major depressive disorder?**
□ Yes □ No □ Not applicable	**If yes to the above question, was the patient evaluated within the previous 6 months and treated by a psychiatrist?**
□ Yes □ No	**Has the patient had a mental health evaluation performed?**
□ Yes □ No	**Does the patient have any of the following?** *(If yes, check which applies)* □ **Was assessed for and determined to have no other causes of involuntary movement** □ **Was evaluated for appropriateness of dose decrease of dopamine receptor blocking agents** □ **Has documentation of tardive dyskinesia severity using a validated scale or assessment of impact on daily function**
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the patient experienced an improvement in tardive dyskinesia severity documented by a validated scale or improvement in daily function?**
□ Yes □ No	**Was the patient re-evaluated and treated for new onset or worsening symptoms of depression and determined to continue to be a candidate for treatment with Ingrezza?**

Provider Signature: _____ **Date:** _____