TEXAS MEDICAID
Clinical Edit Prior Authorization
valbenazine (INGREZZA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of tardive dyskinesia in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of long QT syndrome in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a claim for a monoamine oxidase inhibitor (MAOI) or a strong CYP3A4 inducer in the last 90 days?

   Examples of MAOIs include AZILECT, ENSAM patches, linezolid (ZYVOX), MARPLAN, phenelzine (NARDIL), tranylcypromine (PARNATE), and ZELAPAR.

   Examples of CYP3A4 inducers include APTIOM, ATRIPLA, bexarotene, carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), DUETACT, INTELENCE, LYSODREN, modafinil (PROVIGIL), MYCOBUTIN, primidone (MYSOLINE), nevirapine (VIRAMUNE), ORKAMBI, OSENI, phenobarbital, phenytoin (DILANTIN, PHENYTEK), pioglitazone (ACTPLUS MED, ACTOPLUS MET XR, ACTOS,), PRIFTIN, rifampin (RIFADIN, RIFAMATE, RIFATER), rifabutin, SUSTIVA, TAFINLAR, TARGRETIN, TRACLEER, and XTANDI.

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a claim for tetrabenazine (XENAZINE) or deutetrabenazine (AUSTEDO) in the last 30 days?

☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a diagnosis of moderate to severe hepatic impairment in the last 365 days?

☐ Yes (Go to #8) ☐ No (Go to #7)

7. Does the client have a claim for a strong CYP3A4 inhibitor in the last 90 days?

Examples of strong CYP3A4 inhibitors include clarithromycin (BIAXIN), diltiazem (CARTIA XT, CARDIZEM, MATZIM, TAZTIA, TIAZAC), itraconazole (SPORANOX), ketoconazole, lansoprazole-amoxicillin-clarithromycin, (PREVPAC), nefazodone, OMECLAMOX-PAK, NOXAFIL, TECHNIVIE, KETEK, VICTRELIS, VIEKIRA, voriconazole (VFEND), ZYDELIG, and certain HIV treatments (e.g. CRIXIVAN, EVOTAZ, GENVOYA, INVIRASE, KALETRA, NORVIR, PREZCOBIX, STRIBILD, TYBOST, and VIRACEPT).

☐ Yes (Go to #8) ☐ No (Go to #9)

8. Is the requested dose less than or equal to (≤) one 40 mg capsule per day?

☐ Yes (Approve – 365 days) ☐ No (Deny)

9. Is the requested dose less than or equal to (≤) 1 capsule per day?

☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.