



TEXAS MEDICAID

Drug Prior Authorization

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors: valbenazine (INGREZZA)

Request Information (required)

This request is:

- Expedited* (Urgent)
 Standard (Non-Urgent)

*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)

Prescriber Information (required)

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Is the member greater than or equal to (\geq) 18 years of age?

Yes
(Go to #7)

No (Deny)
(Go to #7)

7. Does the member have a diagnosis of tardive dyskinesia in the last 365 days?

Yes

(Go to #8)

No (Deny)

(Go to #8)

8. Does the member have a diagnosis of long QT syndrome in the last 365 days?

Yes (Deny)

(Go to #9)

No

(Go to #9)

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

Examples of MAOIs include: AZILECT, linezolid (ZYVOX), MARPLAN, phenelzine (NARDIL), selegiline (EMSAM, ZELAPAR) and tranylcypromine (PARNATE).

Examples of CYP3A4 inducers include: armodafinil (NUVIGIL), APTIOM, ATRIPLA, BANZEL, bexarotene, BOSENTAN, carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), clobazam (ONFI), dexamethasone, DUETACT, INTELENCE, LYSODREN, modafinil (PROVIGIL), nevirapine (VIRAMUNE), ORILISSA, ORKAMBI, oxcarbazepine (OXTELLAR XR, TRILEPTAL), OSENI, phenobarbital, phenytoin (DILANTIN, PHENYTEK), pioglitazone (ACTPLUS MET, ACTOPLUS MET XR, ACTOS), PRIFTIN, primidone (MYSOLINE), rifampin (RIFADIN, RIFAMATE, RIFATER), rifabutin (MYCOBUTIN), SUSTIVA, TAFINLAR, TARGRETIN, TRACLEER, XERMELO, XTANDI, and ZELBORAF.

Yes (Deny)

(Go to #10)

No

(Go to #10)

10. Does the member have a claim for tetrabenazine (XENAZINE) or deutetabenazine (AUSTEDO) in the last 30 days?

Yes (Deny)

(Go to #11)

No

(Go to #11)

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

Yes

(Go to #13)

No

(Go to #12)

12. Does the member 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, TOLSURA), ketoconazole, KETEK, KORLYM, lansoprazole -amoxicillin-clarithromycin, (PREVPAC), nefazodone, OMECLAMOX-PAK, NOXAFIL, TECHNIVIE, VICTRELIS, VIEKIRA, voriconazole (VFEND), ZYDELIG, and certain HIV treatments (e.g. atazanavir sulfate [REYATAZ], CRIXIVAN, EVOTAZ, GENVOYA, INVIRASE, KALETRA, PREZCOBIX, PREZISTA, ritonavir [NORVIR], STRIBILD, TYBOST, VIRACEPT).

Yes

(Go to #13)

No

(Go to #14)

13. Is the requested dose less than or equal to (\leq) one (1) 40 mg capsule per day?

Yes (Approve - 365 days)

(Go to #15)

No (Deny)

(Go to #14)

14. Is the requested dose less than or equal to (\leq) one (1) capsule per day?

Yes (Approve 365 days)

(Go to #15)

No (Deny)

(Go to #15)

Additional Information

15. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Customer Care at 877-908-6023

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