



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Ingrezza - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields for Drug Name, Strength, and Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Q1. Is this a request for continuation of therapy with Ingrezza/Ingrezza Sprinkle?

Yes No

Q2. For tardive dyskinesia: does the patient have a documented improvement in symptoms related to tardive dyskinesia with an updated Abnormal Involuntary Movement Scale (AIMS) assessment attached?

Yes No

Q3. For Chorea associated with Huntington's Disease: does the patient have documentation showing Improvement in symptoms of Chorea with medical records attached.

Yes No

Q4. Is the patient 18 years of age or older?

Yes No

Q5. Is Ingrezza being prescribed by or in consultation with a neurologist or psychiatrist?

Yes No



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Patient Name:	Prescriber Name:
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Q6. Has the patient been diagnosed with tardive dyskinesia and has a copy of the Abnormal Involuntary Movement Scale (AIMS) assessment been attached?

Yes

No

Q7. Is there documentation that other movement disorders (such as Parkinson's disease, chorea associated with Huntington's disease) have been excluded with documentation attached?

Yes

No

Q8. Does the patient have documentation of current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine)?

Yes

No

Q9. Does the patient have a diagnosis of Chorea associated with Huntington's Disease with documentation of diagnosis attached?

Yes

No

Q10. Is there documentation that other movement disorders (such as Tardive Dyskinesia, or Parkinson's disease) have been excluded with documentation attached?

Yes

No

Q11. For a diagnosis of Chorea associated with Huntington's Disease: is the patient suicidal or do they have a history of untreated or inadequately treated depression?

Yes

No

Q12. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged QT interval) been excluded?

Yes

No

Q13. Is the request for Ingrezza Sprinkle capsule?

Yes

No



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Patient Name:	Prescriber Name:
Q14. Will Ingrezza be used concurrently with either a monoamine oxidase (MAO) inhibitor or strong cytochrome 3A4 (CYP3A4) inducer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Does the patient have difficulty swallowing solid dosage forms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. Requested Duration: <input type="checkbox"/> 12 Months <input type="checkbox"/> Other:	
Q17. Additional Information:	

Prescriber Signature

Date

2024 Medicare Prior Authorization Request