Movement Disorder Agents (Ingrezza)

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington, Inc. (Apple Health) Preferred Drug list: https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf

For policy criteria, see: https://www.coordinatedcarehealth.com/content/coordinatedcare/en_us/providers/resources/clinical-payment-policies.html/

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response (e.g, reduction in involuntary movements, decrease in total maximal chorea score, or improvement in AIMS or CGI-TD score)?
   ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Chorea associated with Huntington's disease
   ☐ Tardive dyskinesia
   ☐ Other. Specify: _____

3. Is this being prescribed by or in consultation with a psychiatrist or neurologist? ☐ Yes ☐ No

4. Has a baseline assessment been completed using any of the following? Check all that apply:
   ☐ The Unified Huntington's Disease Rating Scale (UHDRS). Specify section completed:
      ☐ Motor
      ☐ Cognitive
      ☐ Behavioral
      ☐ Functional Assessment
      ☐ Independence Scale
      ☐ Total Functional Capacity
   ☐ Abnormal Involuntary Movement Scale (AIMS)
   ☐ Clinical Global Impression of Change – Tardive Dyskinesia (CGI-TD)

5. Will this be used in combination with a monoamine oxidase inhibitor (MAOI) [e.g. isocarboxazid, phenelzine, tranylcypromine, reserpine] or another vesicular monoamine transporter 2 (VMAT2) inhibitor [e.g. tetrabenazine]? ☐ Yes ☐ No

6. Has patient had treatment (minimum of 12 weeks) with deutetrabenazine or deutetrabenazine ER that has been ineffective, not tolerated, or is treatment contraindicated? ☐ Yes ☐ No

7. What alternative treatments has patient tried? _____
   What was the outcome of the trial? _____

If patient has tardive dyskinesia:

8. Does patient continue to experience persistent TD after trying one of the following unless contraindicated, not tolerated, or put patient's psychiatric stability at risk?
   ☐ Switching from a 1st generation to a 2nd generation antipsychotic
   ☐ Patient has tried two 2nd generation antipsychotics
   ☐ Patient has a history of discontinuation or dose modification of the offending medication with continued symptoms

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)