AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Ingrezza

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: (# of days) Initial Request: ___30 ___60 ___90 ___120 ___180
Continuation Request: ___30 ___60 ___90 ___120 ___180 ___365

Clinical Information

1. Does the beneficiary have a diagnosis of moderate to severe Tardive Dyskinesia? Yes___ No___
2. Is the beneficiary age 18 or older? Yes___ No___
3. Has the provider completed baseline evaluations of the condition using either Abnormal Involuntary Movement Scale (AIMS) or Extrapyramidal Symptom Rating Scale (ESRI) along with this request? Yes___ No___
   3a. Please include **AIMS score**: _____ or **ESRI score**: _____
4. Has the beneficiary received a previous trial of an alternative method to manage the condition? Yes___ No___
5. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? Yes___ No___
6. Is the beneficiary concurrently using a MAOI (monoamine oxidase inhibitor) or reserpine? Yes___ No___

****For Continuation of Therapy, answer questions 1-6 and attach documentation that indicates the beneficiary has had an improvement in their symptoms from baseline.****

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406