STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

VALBENAZINE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
VALBENAZINE TOSYLATE	INGREZZA	44202		GPI-10 (6238008020)	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of moderate to severe tardive dyskinesia (TD) and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - Therapy is prescribed by or in consultation with a neurologist, movement disorder specialist, or psychiatrist
   - The patient's moderate to severe TD has been present for at least 3 months
   - The patient has a prior history of using antipsychotic medications (e.g., aripiprazole, haloperidol, ziprasidone) or metoclopramide for at least 3 months (or at least 1 month if patient is 60 years of age or older) as documented in the prescription claims history
   - The patient had a trial of or contraindication to the preferred agent: Austedo (deutetrabenazine)

   If yes, **approve for 12 months by GPID or GPI-14 for all strengths as follows:**
   - **40mg, 60mg, 80mg: #1 per day.**
   - **Initiation pack (40mg-80mg): 1 pack (#28) per fill.**

   If no, continue to #2.

2. Does the patient have a diagnosis of chorea associated with Huntington's disease **AND** meet the following criterion?
   - The patient is 18 years of age or older

   If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #1 per day.**
   If no, do not approve.

   DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **VALBENAZINE (Ingrezza)** requires the following rule(s) be met for approval:
   A. You have ONE of the following diagnoses:
      1. Moderate to severe tardive dyskinesia (TD: uncontrolled body movements)
      2. Chorea (involuntary muscle movements) associated with Huntington's disease (a type of brain disorder)

   (Denial text continued on the next page)

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VALBENAZINE

GUIDELINES FOR USE (CONTINUED)

B. **If you have moderate to severe tardive dyskinesia, approval also requires:**
   1. You are 18 years of age or older
   2. Therapy is prescribed by or in consultation with a neurologist (a type of brain doctor), movement disorder specialist, or psychiatrist (a type of mental health doctor)
   3. Your moderate to severe tardive dyskinesia have been present for at least 3 months
   4. You have a history of using antipsychotic medications (such as aripiprazole, haloperidol, ziprasidone) or metoclopramide for at least 3 months (or at least 1 month if you are 60 years of age or older) as documented in your prescription claims history
   5. You had a trial of or contraindication (harmful for) to the preferred medication: Austedo (deutetrabenazine)

C. **If you have chorea associated with Huntington's disease, approval also requires:**
   1. You are 18 years of age or older

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Ingrezza.

REFERENCES

- Ingrezza [Prescribing Information]. San Diego, CA: Neurocrine Biosciences, Inc; August 2023.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 10/01/23
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P&T Approval: 10/23