OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Ingrezza® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Moderate to severe tardive dyskinesia
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:
Is the patient a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication? ❑ **Yes** ❑ **No**
Has the patient had persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication? ❑ **Yes** ❑ **No**
Has the patient had a history of failure, contraindication, or intolerance to Austedo (deutetrabenazine)? ❑ **Yes** ❑ **No**

Prescriber specialty:
Was the requested medication prescribed by or in consultation with a neurologist or psychiatrist? ❑ **Yes** ❑ **No**

Established Ingrezza therapy:
Is the patient currently on Ingrezza therapy? ❑ **Yes** ❑ **No**
Has the patient received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Neurocrine Biosciences sponsored Inbrace program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Ingrezza? ❑ **Yes** ❑ **No**

Reauthorization:
For reauthorization requests, answer the following:
Is there documentation of positive clinical response to Ingrezza therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.