UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Ingrezza

Program	Prior Authorization
Medication	Ingrezza (valbenazine)
Issue Date	10/2017
Pharmacy and Therapeutics Approval Date	10/2017
Effective Date	12/2017

1. Background:

Ingrezza is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with tardive dyskinesia.

2. Coverage Criteria:

A. Initial Authorization

1. Diagnosis of moderate to severe tardive dyskinesia

-AND-

2. **One** of the following:

   a. Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication

   -OR-

   b. Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

-AND-

3. Prescribed by or in consultation with one of the following:

   - Neurologist
   - Psychiatrist

Authorization will be issued for 12 months.

B. Reauthorization

1. Documentation of positive clinical response to Ingrezza therapy

Authorization will be issued for 12 months.

3. References:

1. Ingrezza Prescribing Information, Neurocrine Biosciences, Inc. April 2017.
2. Hauser RA, Factor SA, Marder SR, et al. Kinect 3: A phase 3 randomized, double-blind, placebo-controlled trial of valbenazine for tardive dyskinesia. American Journal of Psychiatry. May 2017. 174:5.
3. Waln O, Jankovic J: An update on tardive dyskinesia: from phenomenology treatment. Tremor Other Hyperkinet Mov (N Y) 2013; 3: tre-03-161-4138-1.

Program	Prior Authorization –Ingrezza (valbenazine)
Change Control	
Date	Change
10/2017	New program