Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Ingrezza

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a request for continuation of therapy with Ingrezza? If YES, go to 2. If NO, go to 4.

☐ Yes ☐ No

Q2. For tardive dyskinesia: does the patient have a documented improvement in symptoms related to tardive dyskinesia with an updated Abnormal Involuntary Movement Scale (AIMS) assessment attached?

☐ Yes ☐ No

Q3. For Chorea associated with Huntington's Disease: does the patient have documentation showing Improvement in symptoms of Chorea with medical records attached.

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is Ingrezza being prescribed by or in consultation with a neurologist or psychiatrist?

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☐ Yes ☐ No

Q6. Has the patient been diagnosed with tardive dyskinesia and has a copy of the Abnormal Involuntary Movement Scale (AIMS) assessment been attached?

☐ Yes ☐ No

Q7. Is there documentation that other movement disorders (such as Parkinson's disease, chorea associated with Huntington's disease) have been excluded with documentation attached?

☐ Yes ☐ No

Q8. Does the patient have documentation of current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine)?

☐ Yes ☐ No

Q9. Does the patient have a diagnosis of Chorea associated with Huntington's Disease with documentation of diagnosis attached?

☐ Yes ☐ No

Q10. Is there documentation that other movement disorders (such as Tardive Dyskinesia, or Parkinson's disease) have been excluded with documentation attached?

☐ Yes ☐ No

Q11. For a diagnosis of Chorea associated with Huntington's Disease: is the patient suicidal or do they have a history of untreated or inadequately treated depression?

☐ Yes ☐ No

Q12. Have all potential contraindications (including congenital long QT syndrome, arrhythmias associated with prolonged QT interval) been excluded?

☐ Yes ☐ No

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Q13. Is the request for Ingrezza Sprinkle capsule?

☐ Yes ☐ No

Q14. Does the patient have difficulty swallowing solid dosage forms?

☐ Yes ☐ No

Q15. Will Ingrezza be used concurrently with either a monoamine oxidase (MAO) inhibitor or strong cytochrome 3A4 (CYP3A4) inducer?

☐ Yes ☐ No

Q16. Additional Information:

_____ _____

Prescriber Signature Date

v2025