

**NC Medicaid and NC Health Choice  
Pharmacy Prior Approval Request for  
Ingrezza**



**Beneficiary Information**

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

**Prescriber Information**

7. Prescribing Provider NPI #: _____
8. Requester Contact Information Name: _____ Phone #: _____ Ext. _____

**Drug Information**

9. Drug Name: _____	10. Strength: _____	11. Quantity per 30 days: _____				
12. Length of Therapy						
Initial Request (circle # days):	30	60	90	120	180	
Continuation Request (circle # days):	30	60	90	120	180	365

**Clinical Information**

**Initial Request**

1. Does the beneficiary have a diagnosis of moderate to severe Tardive Dyskinesia? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the beneficiary 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the provider submitted documented baseline evaluations of the condition using either Abnormal Involuntary Movement Scale(AIMS) or Extrapyrarnidal Symptom Rating Scale (ESRI) along with this request? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the beneficiary received a previous trial of an alternative method to manage the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list method tried _____
5. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Continuation Request (must also answer questions 1-6 above)**

1. Has the beneficiary met all the above criteria (questions 1-6)? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the provider submitted documentation with this request that indicates the beneficiary has had an improvement in their symptoms from baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No

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 NCTracks at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505