United Healthcare Community Plan

Movement Disorder Agents (Ingrezza)

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _____**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response (e.g, reduction in involuntary movements, decrease in total maximal chorea score, or improvement in AIMS or CGI-TD score)?
   ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Chorea associated with Huntington's disease
   ☐ Tardive dyskinesia
   ☐ Other. Specify: _____

3. Is this being prescribed by or in consultation with a psychiatrist or neurologist? ☐ Yes ☐ No

4. Has a baseline assessment been completed using any of the following? Check all that apply:
   ☐ The Unified Huntington's Disease Rating Scale (UHDRS). Specify section completed:
      ☐ Motor
      ☐ Cognitive
      ☐ Behavioral
      ☐ Functional Assessment
      ☐ Independence Scale
      ☐ Total Functional Capacity
   ☐ Abnormal Involuntary Movement Scale (AIMS)
   ☐ Clinical Global Impression of Change – Tardive Dyskinesia (CGI-TD)

5. Will this be used in combination with a monoamine oxidase inhibitor (MAOI) [e.g. isocarboxazid, phenelzine, tranylcypromine, reserpine] or another vesicular monoamine transporter 2 (VMAT2) inhibitor [e.g. tetrabenazine]? ☐ Yes ☐ No

6. Has patient had treatment (minimum of 12 weeks) with deutetrabenazine or deutetrabenazine ER that has been ineffective, not tolerated, or is treatment contraindicated? ☐ Yes ☐ No

7. What alternative treatments has patient tried?
   What was the outcome of the trial?

If patient has tardive dyskinesia:

8. Does patient continue to experience persistent TD after trying one of the following unless contraindicated, not tolerated, or put patient's psychiatric stability at risk?
   ☐ Switching from a 1st generation to a 2nd generation antipsychotic
   ☐ Patient has tried two 2nd generation antipsychotics
   ☐ Patient has a history of discontinuation or dose modification of the offending medication with continued symptoms

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date