STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Cynthia A. Persily, Ph.D.
Cabinet Secretary

Cynthia Beane
Commissioner

# Office of Pharmacy Services
# Prior Authorization Criteria
# Ingrezza™ (Valbenazine)
***Effective 09/25/2024***

## Prior Authorization Request Form

INGREZZA is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with tardive dyskinesia and for the treatment of adults with chorea associated with Huntington's disease.

**Initial* Prior Authorization Criteria:**

- The patient must be within the age range as recommended by the FDA label; **AND**

- Patient must not be taking an MAOI (at least 14-days post-therapy), reserpine (must be >20 days post therapy) or any other concurrent VMAT2 inhibitor; **AND**

- Prescriber must provide a brief description of the medical necessity of therapy by documenting all target symptoms and their impact on the patient's function and activities of daily living; **AND**

The following indication-specific criteria also apply:

I. **Treatment of Chorea associated with Huntington's Disease:**

1. Must be prescribed by, or in consultation with, a M.D./D.O. neurologist; **AND**

2. Patient must have been evaluated and found not to be suicidal or have untreated/undertreated depression; **AND**

3. All previous therapies must be documented along with their relative benefit. Unless contraindicated, the patient must have a documented 90-day trial, which resulted in intolerance or inadequate treatment response, to **Xenazine (tetrabenazine)**.



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II. **Treatment of Tardive Dyskinesia (TD):**

1. Must be prescribed by, or in consultation with, a M.D./D.O. neurologist or psychiatrist; **AND**

2. Patient must provide a documented clinical diagnosis of tardive dyskinesia meeting DSM-V criteria including:

a) Involuntary athetoid or choreiform movements
b) History of treatment with a dopamine receptor blocking agent (DRBA) such as an antipsychotic or metoclopramide
c) Symptom duration lasting at least 8 weeks; **AND**

3. Prescriber must submit the results of an Abnormal Involuntary Movement Scale (AIMS) exam with every request for prior authorization of Ingrezza; **AND**

4. Prescriber must submit documentation of all other therapies attempted and their associated benefit **(including relevant AIMS scores)**.

***Initial prior-authorization will be for 90 days.**
**Continuation of coverage requires clinically significant improvement in symptoms as compared to that seen using previous therapy.**

## References

1.) Lexi-Comp drug monograph for valbenazine (Reviewed 8/16/2017, 11/2023)
2.) Abnormal Involuntary Movement Scale (AIMS) and Extrapyramidal Symptom Rating Scale (ESRS): cross-scale comparison in assessing tardive dyskinesia. Schizophr Res. 2005 Sep 15;77(2-3):119-28. Gharabawi GM[1], Bossie CA, Lasser RA, Turkoz I, Rodriguez S, Chouinard G.
3.) UpToDate Tardive Dyskinesia: Prevention and Treatment. Article last updated July 24, 2017
4.) American Academy of Neurology Evidence-based guideline: Treatment of tardive syndromes. July 29, 2013.



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