NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval - Treatment for Movement Disorders (Ingrezza)

Beneficiary Information

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #: _____ NPI ☐ *or* Atypical ☐
8. Prescriber Name: _____

Requester Contact Information
Name: _____ Phone #: _____ Ext. _____

Drug Information

9. Drug Name: _____ 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: _____

Clinical Information

1. Is the beneficiary age 18 or greater ☐ Yes ☐ No
2. Does the beneficiary have a diagnosis of moderate to severe Tardive Dyskinesia? ☐ Yes ☐ No
3. Has the prescriber submitted AIMS or ESRI evaluations? ☐ Yes ☐ No
4. Has the beneficiary had a previous trial of an alternative method to manage the Tardive Dyskinesia? ☐ Yes ☐ No
5. Is the Beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ Yes ☐ No
6. Is the Beneficiary receiving concurrent therapy using a MAOI (monoamine oxidase inhibitor) or reserpine? ☐ Yes ☐ No

For re-authorization also answer 7

7. Has documentation been submitted that indicates the Beneficiary has had an improvement in their symptoms from baseline? ☐ Yes ☐ 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: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**