Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Movement Disorders: Ingrezza

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (in Days): Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days
   Continuation Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Does the member have a diagnosis of moderate to severe Tardive Dyskinesia? ☐ **Yes** ☐ **No**
2. Is the member age 18 or older? ☐ **Yes** ☐ **No**
3. Has the provider completed baseline evaluations of the condition using either Abnormal Involuntary Movement Scale (AIMS) or Extrapyramidal Symptom Rating Scale (ESRI) along with this request? ☐ **Yes** ☐ **No**
4. Has the member had a previous trial of an alternative method to manage the condition? ☐ **Yes** ☐ **No**
5. Is the member receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ **Yes** ☐ **No**
6. Is the member concurrently using a MAOI (monoamine oxidase inhibitor) or reserpine? ☐ **Yes** ☐ **No**

**** For Continuation of Therapy: answer questions 1-6 and attach documentation that indicates the member has had an improvement in their symptoms from baseline. ****

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.