Statement of Medical Necessity Information Form for INGREZZA™ (valbenazine) or AUSTEDO® (deutetrabenazine)

Fax the completed form requesting INGREZZA™ OR AUSTEDO® and chart notes to 1-800-424-5851 for review.

Patient information:	**Provider information:**
	Name:_____
Name:_____	Medicaid ID: _____
DOB: _____	Phone:_____
Medicaid ID: _____	Fax:_____
INITIAL REQUEST: _____	Specialty:_____
RENEWAL REQUEST: _____	Contact Person: _____

In order to complete the review for the requested PA, all questions must be completed on this form and the prescriber is required to submit chart notes with this completed form.

STATE NAME OF DRUG AND DOSE REQUESTED: _____

1. List any oral, facial, and lingual dyskinesia symptoms observed: _____

_____

2. List any dyskinesia symptoms of the limbs observed: _____

_____

3. List any dyskinesia symptoms of the neck and trunk observed:_____

_____

4. Do any of the dyskinesia symptoms observed interfere with activities or functions of daily living? If so, list all that apply and describe interference: _____

_____

5. List all known past dopamine receptor blocking agents (e.g. antipsychotic agents or metoclopramide) and length of therapy of each: _____

_____

_____

6. List any recent changes to antipsychotic drug therapy the patient is receiving: _____

_____

7. List all currently prescribed medications and dose:_____

_____

Prescriber Signature_____ **Date:** _____

(Rubber stamp or electronic signature not accepted)

Prescriber name: (please print)_____

This signature certifies that the information provided in the Statement of Medical Necessity is accurate and substantiated by the patient's medical records. The prescriber also agrees that Medicaid may audit this patient's medical records to ascertain the medical necessity for accuracy of data submitted.