UnitedHealthcare Community Plan

Ingrezza
Prior Authorization Request Form

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.

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:

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
☐ Yes ☐ No	**Does the patient have a diagnosis of moderate to severe tardive dyskinesia?**
☐ Yes ☐ No	**Does the patient have persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication?** *(If yes, complete Section D above)*
☐ Yes ☐ No	**Is the patient a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication?**
☐ Yes ☐ No	**Is Ingrezza prescribed by or in consultation with any of the following?** *(If yes, check which applies)* ☐ Neurologist ☐ Psychiatrist
CONTINUATION OF THERAPY	
☐ Yes ☐ No	**Is there documentation of positive clinical response to Ingrezza therapy?**

Provider Signature: ____ **Date:** ___________________

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