Print Reset

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

Fax the completed form requesting Ingrezza® **or** Austedo® and chart notes to Arkansas Medicaid Pharmacy Unit for review.

Fax: 1-800-424-5851 For questions call: 501-683-4120

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per beneficiary. Information contained in this form is Protected Health Information under HIPAA.

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Medicaid ID: _____ Beneficiary's Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ DEA #: _____

Specialty: _____ Prescriber Medicaid ID: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Contact Person (if additional info needed): _____

DRUG INFORMATION

☐ Initial Request ☐ Renewal Request

Drug Name: _____ Drug Strength: _____

Drug Form: _____ Quantity: _____

Dosing: _____

Diagnosis:

Patient's Full Name: _____

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

CRITERIA

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:

☐ Attachments

Prescriber Signature: _____ Date: _____

(**Prescriber's original signature required; copied, stamped, or e-signature are not allowed.**) **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.

Prescriber Last Name: _____

Prescriber First Name: _____

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