| Market Applicability/Effective Date | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Market** | **DC** | **FL & FHK** | **FL MMA** | **FL LTC** | **GA** | **KS** | **KY** | **LA** | **MD** | **NJ** | **NV** | **NY** | **TN** | **TX** | **WA** |
| **Applicable** | X | X | N/A | N/A | X | N/A | X | X | X | X | X | X | N/A | N/A | NA |

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# Ingrezza (valbenazine)

| Override(s) | Approval Duration |
|---|---|
| Prior Authorization<br>Quantity Limit | 1 year |

| Medications | Quantity Limit |
|---|---|
| Ingrezza (valbenazine) | May be subject to quantity limit |

## APPROVAL CRITERIA

Initial requests for Ingrezza (valbenazine) may be approved for individuals who meet the following criteria:

I. Individual is 18 years of age or older; **AND**
II. Individual has a diagnosis of tardive dyskinesia (TD) confirmed by the following (DSM-5):
    A. At least 60 days of stable (drug, dose) medication exposure (either typical or first generation antipsychotic agents [such as, chlorpromazine, haloperidol, fluphenazine], atypical or second-generation antipsychotic agents [such as, clozapine, risperidone, olanzapine, quetiapine, aripiprazole], or certain dopamine receptor-blocking drugs used in treatment of nausea and gastroparesis [such as, prochlorperazine, promethazine, metoclopramide]); **AND**
    B. Presence of involuntary athetoid or choreiform movements lasting at least 30 days.

Requests for continuation of therapy for Ingrezza (valbenazine) may be approved for individuals who meet the following criteria:

I. Individual has experienced an improvement in symptoms deemed to be clinically significant by the provider.

Requests for Ingrezza (valbenazine) **may not** be approved for individuals who meet the following criteria:

I. Individual has congenital long QT syndrome or arrhythmia associated with a prolonged QT interval; **OR**
II. Individual is currently using a strong CYP 3A4 Inducer (examples: rifampin, carbamazepine, phenytoin, St. John's wort); **OR**
III. Individual is currently using a monoamine oxidase inhibitor (MAOI) (examples: isocarboxazid, phenelzine, selegiline).

| Market Applicability/Effective Date | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Market** | **DC** | **FL & FHK** | **FL MMA** | **FL LTC** | **GA** | **KS** | **KY** | **LA** | **MD** | **NJ** | **NV** | **NY** | **TN** | **TX** | **WA** |
| **Applicable** | X | X | N/A | N/A | X | N/A | X | X | X | X | X | X | N/A | N/A | X |

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| State Specific Mandates | | |
|---|---|---|
| State name<br>N/A | Date effective<br>N/A | Mandate details (including specific bill if applicable)<br>N/A |

**Key References**:


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This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.