UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1235-11
Program	Prior Authorization/Notification
Medication	Ingrezza® (valbenazine)
P&T Approval Date	11/2017, 11/2018, 11/2019, 11/2020, 6/2021, 6/2022, 6/2023, 10/2023, 4/2024, 4/2025, 4/2026
Effective Date	7/1/2026

1. Background:

Ingrezza® (valbenazine)is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with tardive dyskinesia and chorea associated with Huntington's disease.[1]

2. Coverage Criteria[a]:

A. Tardive Dyskinesia

1. **Initial Authorization**

a. **Ingrezza** will be approved based on the following criterion:

(1) Diagnosis of tardive dyskinesia

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Documentation of positive clinical response to Ingrezza therapy

Authorization will be issued for 12 months.

B. Chorea associated with Huntington's disease

1. **Initial Authorization**

a. **Ingrezza** will be approved based on the following criterion:

(1) Diagnosis of chorea associated with Huntington's disease

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Documentation of positive clinical response to Ingrezza therapy

Authorization will be issued for 12 months.

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[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Step Therapy, and/or Medical Necessity may be in place.

4. References:

1. Ingrezza [package insert]., San Diego, CA: Neurocrine Biosciences, Inc.; February 2025

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Change Control	
11/2017	New program
11/2018	Annual review. No changes to clinical coverage criteria. Updated reference.
11/2019	Annual review. No changes to clinical coverage criteria. Updated reference.
11/2020	Annual review. Updated reference.
6/2021	Added Ingrezza exclusion statement. Updated reference.
6/2022	Annual review. No updates.
6/2023	Annual review. Updated reference.
10/2023	Added criteria for chorea associated with Huntington's disease. Updated background and reference.
4/2024	Removed notation that Ingrezza is typically excluded.
4/2025	Annual review. No changes to clinical coverage criteria. Updated reference.
4/2026	Annual review. No changes to clinical coverage criteria.

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