UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1235-8
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
Effective Date	1/1/2024

1. Background:
Ingrezza* 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.

[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.

*Ingrezza is excluded from coverage for the majority of our benefits

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.; August 2023

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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.