

# Criteria Based Consultation Prescribing Program

## CRITERIA FOR DRUG COVERAGE

### Valbenazine (Ingrezza)

**Notes:**

- Quantity limits: Yes

**Initiation (new start) criteria:** Non-formulary **valbenazine (Ingrezza)** will be covered on the prescription drug benefit for 12 months when the following criteria are met:

- Prescriber is a neurology or mental health clinician
- Patient has a diagnosis of tardive dyskinesia with symptoms present for at least 3 months
- Patient has history of antipsychotic medication, antidepressant medication, or metoclopramide use
- Abnormal movements are rated as moderate or severe indicated by either:
  - Abnormal Involuntary Movement Scale [AIMS] score  $\geq 10$  **OR**
  - Severity noted to be “moderate” or “severe” by prescriber **OR**
  - AIMS item 8 score of 3 or 4
- Deutetrabenazine is NOT being used concurrently with another vesicular monoamine transporter 2 (VMAT2) inhibitor, a monoamine oxidase inhibitor (MAOI), or reserpine.

**Continued use criteria (12 months after initiation):** Non-formulary **valbenazine (Ingrezza)** will continue to be covered on the prescription drug benefit when the following criteria are met:

- Clinically significant improvement in abnormal movements verified by AIMS score or clinician observation