

Fax the completed form requesting INGREZZA™ OR AUSTEDO® and chart notes to 1-800-424-5851 for review.

Patient information:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_

INITIAL REQUEST: \_\_\_\_\_

RENEWAL REQUEST: \_\_\_\_\_

Provider information:

Name: \_\_\_\_\_

Medicaid ID: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Specialty: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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

STATE NAME OF DRUG AND DOSE REQUESTED: \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

Prescriber Signature \_\_\_\_\_  
(Rubber stamp or electronic signature not accepted)

Date: \_\_\_\_\_

Prescriber name: (please print) \_\_\_\_\_

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.