SPECIALTY GUIDELINE MANAGEMENT

INGREZZA™(valbenazine)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
Treatment of adults with tardive dyskinesia

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Tardive dyskinesia
Authorization of 3 months may be granted for members requesting Ingrezza for the treatment of tardive dyskinesia related to drug use and the prescriber indicates that dose reduction or discontinuation of the causative drug is not an option.

III. CONTINUATION OF THERAPY

Coverage may be renewed for 12 months in situations where there has been an improvement in signs and symptoms of tardive dyskinesia.

IV. REFERENCES

1. Ingrezza [package insert]. San Diego, CA: Neurocrine Biosciences, Inc.; April 2017.
2. Hauser, Robert, et al. KINECT-3: A Phase 3 Randomized, Double-Blind, Placebo-Controlled Trial of Velbenazine for Tardive Dyskinesia. *American Journal of Psychiatry.* 2017 Mar 21: 1-9.