

Drug Policy

Policy:	Ingrezza and Ingrezza Sprinkle (valbenazine capsules – Neurocrine Biosciences)	Annual Review Date: 07/17/2025 Last Revised Date: 07/17/2025
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OVERVIEW

Ingrezza and Ingrezza Sprinkle, vesicular monoamine transporter type 2 inhibitors, are indicated in adults for the following uses:¹

- **Chorea associated with Huntington’s disease.**
- **Tardive dyskinesia.**

POLICY STATEMENT

This policy involves the use of Ingrezza. Prior authorization is recommended for pharmacy benefit coverage of Ingrezza. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Ingrezza as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Ingrezza be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Ingrezza is recommended in those who meet the following criteria:

Food and Drug Administration (FDA)-Approved Indications

1. **Tardive Dyskinesia (TD), Initial Therapy**

Criteria. *Patient must meet the following criteria (a, b, and c)*

- a. Patient is 18 years of age or older; AND
- b. Ingrezza is prescribed by or in consultation with a neurologist or psychiatrist; AND
- c. Patient has been clinically diagnosed with TD according to the DSM V Criteria* (i, ii, and iii):
 - i. Involuntary athetoid or choreiform movements; AND
 - ii. History of treatment with a neuroleptic agent (i.e. antipsychotic); AND
 - iii. Symptoms lasting longer than 4-8 weeks

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2. Tardive Dyskinesia (TD), Patient is Currently Receiving Therapy

Criteria. Patient must meet the following criteria (a, b, and c):

- a. Patient is 18 years of age or older; AND
- b. Ingrezza is prescribed by or in consultation with a neurologist or psychiatrist; AND
- c. The patient has experienced improvement in, or maintenance of, symptoms while on the requested medication.*

Note: Examples of response to therapy include reduction in AIMS or DISCUS score from baseline.

3. Chorea associated with Huntington's Disease, Initial Therapy

Criteria. Patient must meet the following criteria (a, b, c, and d):

- a. Patient is 18 years of age or older; AND
- b. Diagnosis of Huntington's Disease is confirmed by genetic testing (for example, an expanded HTT CAG repeat sequence of at least 36)*; AND
- c. Ingrezza is prescribed by or in consultation with a neurologist or psychiatrist; AND
- d. The patient has tried a tetrabenazine product (generic tetrabenazine or brand Xenazine) and has demonstrated inadequate efficacy or unacceptable safety or tolerability to a tetrabenazine product, according to the prescribing physician*.

4. Chorea associated with Huntington's Disease, Continuing Therapy

Criteria: Patient must meet the following criteria (a, b, and c):

- a. Patient is 18 years of age or older; AND
- b. Ingrezza is prescribed by or in consultation with a neurologist or psychiatrist; AND
- c. The patient has experienced improvement in, or maintenance of, symptoms while on the requested medication*.

Note: Examples of response to therapy include improvement in TMC score and improvement in overall motor function.

Initial Approval/ Extended Approval.

A) *Initial Approval:* 1 year (365 days)

B) *Extended Approval:* 1 year (365 days)

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Ingrezza has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

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1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

***Documentation Requirements:**

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company.

Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Ingrezza® capsules [prescribing information]. San Diego, CA: Neurocrine Biosciences, Inc.; August 2023.
2. American Psychiatric Association. (2013). Medication-induced movement disorders and other adverse effects of medication. In Diagnostic and statistical manual of mental disorders (5th ed.). Available at: <http://dx.doi/full/10.1176/appi.books.9780890425596.MedicationInduced#x45151.2829056>. Accessed on May 15, 2017.
3. Bhidayasiri R, Fahn S, Weiner WJ, et al. Evidence-based guideline: treatment of tardive syndromes: report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2013;81(5):463-469.
4. Valbenazine. In: DRUGDEX (online database). Truven Health Analytics; Greenwood Village, CO. Last updated on 18 June 2019. Accessed on 15 July 2019.