Summit COMMUNITY CARE

Arkansas | Medicaid

Statement of Medical Necessity — Ingrezza® (valbenazine) or Austedo® (deutetrabenazine)

Instructions

Fax the completed form requesting Ingrezza® or Austedo® and chart notes to Summit Community Care for review:

- Fax number: **844-429-7761**
- For questions, call **844-462-0022**

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per patient. Information contained in this form is protected health information under *HIPAA.*

Member information		Prescriber information	
Member last name:		Prescriber last name:	
Member first name:		Prescriber first name:	
Medicaid ID:		Prescriber NPI:	
DOB:		DEA No.:	
Street address:		Specialty:	
City:		Medicaid ID:	
State:		Street address:	
ZIP:		City:	
		State:	
		ZIP:	
		Phone:	
		Fax:	
		Person to contact if more information is needed:	

Drug information

☐ Initial request ☐ Renewal request	
Drug name:	
Drug strength:	
Drug form:	
Quantity:	

Member:

Dosing:	

Diagnosis

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.

Criteria

List any oral, facial, and lingual dyskinesia symptoms observed:

List any dyskinesia symptoms of the limbs observed:

List any dyskinesia symptoms of the neck and trunk observed:

Do any of the dyskinesia symptoms observed interfere with activities or functions of daily living? If so, list all that apply and describe interference:

List all known past dopamine receptor blocking agents (such as antipsychotic agents or metoclopramide) and length of therapy of each:

List any recent changes to antipsychotic drug therapy the patient is receiving:

Member:

List all currently prescribed medications and dose:

☐ Attachments

Prescriber signature

Date

Prescriber's original signature is required — a copied, stamped, or e-signature is not allowed.

This signature certifies that the information provided in this form 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.

Prescriber last name:	
Prescriber first name:	

Fax the completed form requesting Ingrezza® or Austedo® and chart notes to **844-429-7761**.

Email is the quickest and most direct way to receive important information from us.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the left or via our online form: **https://bit.ly/signup-summit-ar**.