



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Ingrezza

Page: 1 of 2

Effective Date: 1/3/2024

Last Review Date: 11/2023

Applies to:	<input checked="" type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Texas

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Ingrezza under the patient's prescription drug benefit.

### Description:

#### FDA-Approved Indications

Treatment of adults with:

- A. Tardive dyskinesia
- B. Chorea associated with Huntington's disease

All other indications are considered experimental/investigational and not medically necessary.

### Applicable Drug List:

Ingrezza

### Policy/Guideline:

#### Documentation:

Submission of the following information is necessary for both initial approval and continuation of therapy prior authorization reviews (where applicable): Documentation of score of items 1 to 7 of the Abnormal Involuntary Movement Scale (AIMS).

#### Criteria for Initial Approval:

##### A. Tardive dyskinesia

Authorization of 6 months may be granted for treatment of tardive dyskinesia when the baseline AIMS score for items 1 to 7 is obtained.

##### B. Chorea associated with Huntington's disease

Authorization of 6 months may be granted for treatment of chorea associated with Huntington's disease when both of the following criteria are met:

1. Member demonstrates characteristic motor examination features
2. Member meets one of the following conditions:
  - i. Laboratory results indicate an expanded *HTT* CAG repeat sequence of at least 36
  - ii. Member has a positive family history for Huntington's disease

#### Criteria for Continuation of Therapy:

##### A. Tardive dyskinesia



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Authorization of 12 months may be granted for treatment of tardive dyskinesia when the member's tardive dyskinesia symptoms have improved as indicated by a decreased AIMS score (items 1 to 7) from baseline.

#### **B. Chorea associated with Huntington's disease**

Authorization of 12 months may be granted for treatment of chorea associated with Huntington's disease when the disease has improved or stabilized.

#### **Approval Duration and Quantity Restrictions:**

##### **Approval:**

- Initial approval: 6 months
- Renewal: 12 months

##### **Quantity Level Limit:**

- Ingrezza 40 mg capsule: 30 per 30 days
- Ingrezza 60 mg capsule: 30 per 30 days
- Ingrezza 80 mg capsule: 30 per 30 days
- Ingrezza 4-week Initiation Pack (7- 40 mg capsules, 21- 80 mg capsules): 1 pack (28 capsules) per 28 days
- Ingrezza 4-week Initiation Pack (14 x 40 mg capsules, 14 x 60 mg capsules): 1 pack (28 capsules) per 28 days

##### **References:**

1. Ingrezza [package insert]. San Diego, CA: Neurocrine Biosciences, Inc.; August 2023.
2. Hauser, Robert, et al. KINECT-3: A Phase 3 Randomized, Double-Blind, Placebo-Controlled Trial of Valbenazine for Tardive Dyskinesia. *American Journal of Psychiatry*. 2017 Mar 21: 1-9.
3. American Psychiatric Association. (2021). *Practice Guideline for the Treatment of Patients With Schizophrenia, third edition*. <https://doi.org/10.1176/appi.books.9780890424841>.
4. Armstrong MJ, Miyasaki JM. Evidence-based guideline: pharmacologic treatment of chorea in Huntington disease: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2012; 79(6):597-603.
5. Stimming EF, Claassen DO, Kayson E, et al. Safety and efficacy of valbenazine for the treatment of chorea associated with Huntington's disease (KINECT-HD): a phase 3, randomized, double-blind, placebo-controlled trial. *Lancet Neurol*. 2023; 22:494-504.