



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Ingrezza

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Effective Date: 8/13/2025

Last Review Date: 7/2025

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

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:

Preferred Agent: Ingrezza

Policy/Guideline:

Documentation:

Submission of the following information is necessary to initiate the prior authorization review for initial requests:

- A. Tardive dyskinesia: Chart notes or medical record documentation of clinical manifestations of disease.
- B. Chorea associated with Huntington's disease: Chart notes or medical record documentation of characteristic motor examination features.

Criteria for Initial Approval:

A. Tardive dyskinesia

Authorization of 6 months may be granted for treatment of tardive dyskinesia when BOTH of the following criteria are met:

1. Member exhibits clinical manifestations of disease.
2. Member's tardive dyskinesia has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS]).

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:



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- 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

Authorization of 12 months may be granted for members with an indication of Tardive Dyskinesia who are experiencing benefit from therapy as evidenced by disease stability or disease improvement..

B. Chorea associated with Huntington's disease

Authorization of 12 months may be granted for members with an indication of Chorea associated with Huntington's disease who are experiencing benefit from therapy as evidenced by disease stability or disease improvement.

Approval Duration and Quantity Restrictions:

Approval:

- Initial approval: 6 months
- Renewal approval: 12 months

Quantity Level Limit:

- Ingrezza 40 mg capsule/sprinkle: 30 per 30 days
- Ingrezza 60 mg capsule/sprinkle: 30 per 30 days
- Ingrezza 80 mg capsule/sprinkle: 30 per 30 days
- Ingrezza 4-week Initiation Pack (7-40mg caps, 21-80 mg caps): 1 pack (28 caps) per 28 days

References:

1. Ingrezza [package insert]. San Diego, CA: Neurocrine Biosciences, Inc.; February 2025.
2. Hauser RA, Factor SA, Marder SR, et al. KINECT-3: a phase 3 randomized, double-blind, placebo-controlled trial of valbenazine for tardive dyskinesia. *Am J Psychiatry*. 2017;174(5):476-484.
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. 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.