# VESICULAR MONOAMINE TRANSPORTER 2 INHIBITORS

**Included Products: Ingrezza (valbenazine), Ingrezza Sprinkle (valbenazine), Xenazine (tetrabenazine)**

*Created*: 05/09/2019 *Revised*: 09/12/2024 *Reviewed*: 09/12/2024 *Updated*: 10/01/2024

| All Diagnoses | | | |
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| **Initial Criteria** | | **If yes** | **If no** |
| **1.** | Is the request for Ingrezza? | Continue to #2. | Continue to #4. |
| **2.** | Has the treatment been initiated by or is an appropriate specialist (PMHNP and other mid-level excluded) currently supervising it?<br>a. Huntington's Chorea: neurologist<br>b. Tardive Dyskinesia: neurologist or psychiatrist | Continue to #3. | Do not approve. |
| **3.** | Has the member tried and failed or have contraindications to tetrabenazine that are not also contraindications to Ingrezza? | Continue to #4. | Do not approve. |
| **4.** | Continue to diagnosis. | | |

| Huntington's Chorea | | | |
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| **Initial Criteria** | | **If yes** | **If no** |
| **1.** | Is the diagnosis Huntington's Chorea? | Continue to #2. | Do not approve. |
| **2.** | Did the provider submit medical record documentation on the degree of chorea and impact on functional ability and/or quality of life as a baseline? | Continue to #3. | Do not approve. |
| **3.** | Did the provider submit medical record documentation of an assessment of mental status specifically for depression and suicidality? | Continue to #4. | Do not approve. |
| **4.** | Approve for 6 months. | | |

| Renewal Criteria | | If yes | If no |
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| **1.** | Is there documentation of a clinical response such as improvement in chorea, ability to perform activities of daily living, reduction in falls, or increase in quality of life? | Continue to #2. | Do not approve. |
| **2.** | Has there been close observation for the emergence or worsening of depression, suicidality, or unusual changes in behavior while on therapy? | Continue to #3. | Do not approve. |
| **3.** | Is the requested maintenance dose properly adjusted based on current medication regimen and metabolizer status? (If tetrabenazine dose over 50mg per day, CYP2D6 genotyping is required.) | Continue to #4. | Do not approve. |
| **4.** | Approve 12 months. | | |

# Tardive Dyskinesia

| Initial Criteria | | If yes | If no |
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| **1.** | Does the member have a documented clinical diagnosis of tardive dyskinesia (TD) including the following:<br>a. At least one month of past or current exposure to a dopamine receptor blocker.<br>b. Dyskinetic or dystonic involuntary movements.<br>c. Exclusion of other causes of abnormal movements. | Continue to #2. | Do not approve. |
| **2.** | Is there clear documentation the tardive dyskinesias meets one of the following:<br>a. Causing significant functional impairment<br>b. Progression of TD symptoms worsening over time<br>c. Causing significant distress to the member | Continue to #3. | Do not approve. |
| **3.** | Did the provider submit medical record documentation on the degree of tardive dyskinesia with the AIMS scale as a baseline? | Continue to #4. | Do not approve. |
| **4.** | Has therapy modification of the dopamine receptor blocker been done satisfying one of the following: | Continue to #5. | Do not approve. |

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| | a. Medication(s) precipitating the tardive dyskinesia has been discontinued, but tardive dyskinesia persists.<br>b. At least 8 weeks trial of each of TWO other agents within the same therapeutic category at a clinically effective and maximum tolerated dose for the member's primary neuropsychiatric diagnoses.<br>c. Documentation that therapy change of the medication(s) precipitating the tardive dyskinesia could cause harm or is otherwise inappropriate. | | |
| **5.** | Approve for 6 months. | | |
| Renewal Criteria | | If yes | If no |
| **1.** | Is there documentation of BOTH of the following:<br>a. Follow-up AIMS assessment showing improvement from baseline, AND<br>b. Documentation of improved functioning, such as ability to perform activities of daily living or increase in quality of life? | Continue to #2. | Do not approve. |
| **2.** | Is the requested maintenance dose properly adjusted based on current medication regimen and metabolizer status? | Continue to #3. | Do not approve. |
| **3.** | Approve for 12 months. | | |

# Tourette Syndrome

| Initial Criteria | | If yes | If no |
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| **1.** | Does the member have a documented clinical diagnosis of Tourette Syndrome (TS) including:<br>a. Onset is before age 21 years<br>b. Multiple motor and one or more vocal tics are present<br>c. Exclusion of other causes of tics, such as substances or medical conditions. | Continue to #2. | Do not approve. |
| **2.** | Is there clear documentation that the Tourette syndrome causes significant functional impairment? | Continue to #3. | Do not approve. |
| **3.** | Did the provider submit medical record | Continue to #4. | Do not approve. |

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| | documentation on the degree of Tourette syndrome with the Yale Global Tic Severity Score (YGTSS) as a baseline? | | |
| **4.** | Has the member tried and failed TWO of the following or have a contraindication to all?<br>a. an alpha-2 agonist<br>b. topiramate<br>c. aripiprazole (or other atypical antipsychotic)<br>d. haloperidol or pimozide | Continue to #5. | Do not approve. |
| **5.** | Approve for 6 months. | | |
| Renewal Criteria | | If yes | If no |
| **1.** | Is there documentation of BOTH of the following:<br>a. Follow-up Yale Global Tic Severity Score (YGTSS) showing improvement from baseline.<br>b. Documentation of improved functioning, such as ability to perform activities of daily living or increase in quality of life? | Continue to #2. | Do not approve. |
| **2.** | Is the requested maintenance dose properly adjusted based on current medication regimen and metabolizer status? | Continue to #3. | Do not approve. |
| **3.** | Approve for 12 months. | | |