

# PRIOR AUTHORIZATION REQUEST FORM

# **PARKINSON'S AGENTS**

Apomorphine hydrochloride injection, Duopa™, Kynmobi™, Neupro®, Nourianz™, Ongentys®, Rytary®, Tasmar®, tolcapone, Zelapar®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

# Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695								
Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.								
Date:		Member Name:		ID#:	ID#:			
DOB:		Gender:		Phys	Physician:			
Office Phone:		Office Fax:			Office Contact:			
Hei	Height/Weight:							
Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.  Product being requested: □ apomorphine hydrochloride injection, □ Duopa™ (levodopa/carbidopa enteral suspension), □ Kynmobi™, □ Neupro® (rotigotine patch), □ Nourianz™ (istradefylline), □ Ongentys® (opicapone), □ Rytary® (carbidopa/levodopa extended release), □ tolcapone, □ Zelapar® (selegiline hydrochloride ODT)  Dosing/Frequency: □ If the request is for reauthorization, proceed to reauthorization section.								
	If the request is	for reauthorization, proceed	to reau	ıthorizat	ion section.			
	•		to reau	ıthorizat No				
1.	If the request is  Questions  Does the member have a diagnosis				ion section.  Comments/Notes  Please provide documentation			
	Questions		Yes	No	Comments/Notes			
2. 3.	Questions  Does the member have a diagnosis  Is the prescriber a neurologist?  Has the member had an inadequate	of Parkinson's disease?	Yes	No	Comments/Notes			
2. 3.	Questions  Does the member have a diagnosis  Is the prescriber a neurologist?  Has the member had an inadequate levodopa/carbidopa therapy?	of Parkinson's disease? e response to oral	Yes	No	Comments/Notes Please provide documentation			
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	DUOPA™							
1.	Is the request for Duopa™?							
2.	Is the member responsive to levodopa with defined "on" periods?			Please provide documentation				
3.	Is the member experiencing ≥3 hours of "off" episodes despite maximally tolerated levodopa/carbidopa and one other class of anti-Parkinson's disease therapy (dopamine agonist, pramipexole or ropinirole), COMT inhibitor (entacapone), or			Please provide documentation				
1	MAO-B inhibitor (selegiline)?  Has the member undergone or has a planned placement of a							
÷	PEG-J tube?							
	KYNMOBI™							
1.	Is the request for Kynmobi™?							
2.	Will the member be concurrently taking levodopa/carbidopa with Kynmobi™ therapy?							
3.	Is the member experiencing "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) associated with advanced Parkinson's disease?			Please provide documentation				
	Has the member had a trial and failure or contraindication/intolerance to a preferred dopamine agonist (pramipexole, ropinirole), COMT inhibitor (entacapone), or MAO-B inhibitor (selegiline)?			Please provide documentation				
5.	Will the member be taking a 5HT3 antagonist concurrently with Kynmobi™?							
	NEUPRO®							
1.	Is the request for Neupro®?							
2.	Is the member unable to take medications by mouth or is oral			Please provide documentation				
	therapy clinically inappropriate?							
3.	Has the member had a trial and failure or contraindication/intolerance to at least two of the following, one of which must be an extended release product: ropinirole, pramipexole, bromocriptine?			Please provide documentation				
	NOURIANZ™							
	Is the request for Nourianz <sup>™</sup> ?							
2.	Will the member be concurrently taking levodopa/carbidopa with Nourianz <sup>TM</sup> therapy?							
3.	Is the member experiencing ≥2 hours of "off" episodes associated with advanced Parkinson's disease despite maximally tolerated levodopa/carbidopa and two other classes of anti-Parkinson's disease therapy (dopamine agonist, pramipexole or ropinirole), COMT inhibitor (entacapone), or MAO-B inhibitor (selegiline)?			Please provide documentation				
ONGENTYS®								
	Is the request for Ongentys®?							
2.	Will the member be concurrently taking levodopa/carbidopa with Ongentys® therapy?							
3.	Is the member experiencing ≥2 hours of "off" episodes associated with advanced Parkinson's disease despite maximally tolerated levodopa/carbidopa and two other classes of anti-Parkinson's disease therapy (dopamine agonist,			Please provide documentation				

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	xole or ropinirole), COMT inhibitor (entacapone), or nhibitor (selegiline)?							
RYTARY®								
1. Is the re	quest for Rytary®?	Τп	П					
	member had at least a 3-month trial and failure or			Please provide documentation				
	dication to generic extended-release			p. 0.1.00				
	pa/levodopa?							
TOLCAPONE								
1. Is the re	quest for tolcapone generic tablets?							
2. Has the	member had a 3-month trial and failure or			Please provide documentation				
contrain	dication/intolerance to entacapone or		_	•				
	a/carbidopa/entacapone?							
	member be concurrently taking levodopa/carbidopa							
	capone therapy?							
	ZELAPAR®							
1. Is the re	quest for Zelapar®?							
2. Has the	member exhibited deterioration in the quality of their			Please provide documentation				
response	e to levodopa/carbidopa?							
3. Has the	member had a trial and failure or contraindication/			Please provide documentation				
intolerar	nce to conventional selegiline tablets?							
4. Will the	member be concurrently taking levodopa/carbidopa							
with Zela	apar® therapy?							
	REAUTHORIZATIO	N						
1. Is the re	questing for reauthorization of therapy?							
2. Has the	therapy shown to be effective with a positive clinical			Please provide documentation				
response	e?							
What medi	cations and/or treatment modalities have been tried ir	the pa	st for this	condition? Please document				
name of tre	atment, reason for failure, treatment dates, etc.							
Additional information:								
Physician Signature:								
Physician signature:								
i e								

\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\*

Policy PHARM-089

Origination Date: 01/30/2020 Reviewed/Revised Date: 03/15/2023 Next Review Date: 03/15/2024 Current Effective Date: 04/01/2023

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