HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
NEUPRO® FOR RESTLESS LEGS

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

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: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
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 request: ☐ Neupro® (rotigotine)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for moderate-to-severe Restless Legs Syndrome?	☐	☐	
2. If serum ferritin levels are ≤75 mcg/L, has the member had a 3-month trial and failure of oral iron?	☐	☐	**Please provide documentation**
3. Has the patient tried and failed all of the following: ropinirole, pramipexole, pregabalin?	☐	☐	**Please provide documentation**
4. Is the patient unable to take medications by mouth or is oral therapy clinically inappropriate?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Do updated progress notes show continued medical necessity and clinical efficacy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician’s Signature:

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Policy: PHARM-CHIP-047
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024