

HEALTHY U CHIP

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 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 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.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the prescriber a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had an inadequate response to oral levodopa/carbidopa therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

APOMORPHINE HYDROCHLORIDE INJECTION

1. Is the request for apomorphine hydrochloride injection?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will the member be concurrently taking levodopa/carbidopa with apomorphine hydrochloride injection therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member experiencing "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) associated with advanced Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. 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)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Will the member be taking a 5HT3 antagonist concurrently with apomorphine hydrochloride injection?	<input type="checkbox"/>	<input type="checkbox"/>	

DUOPA™			
1. Is the request for Duopa™?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member responsive to levodopa with defined “on” periods?	<input type="checkbox"/>	<input type="checkbox"/>	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 MAO-B inhibitor (selegiline)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member undergone or has a planned placement of a PEG-J tube?	<input type="checkbox"/>	<input type="checkbox"/>	
KYNMOBI™			
1. Is the request for Kynmobi™?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will the member be concurrently taking levodopa/carbidopa with Kynmobi™ therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member experiencing “off” episodes (“end-of-dose wearing off” and unpredictable “on/off” episodes) associated with advanced Parkinson’s disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. 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)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Will the member be taking a 5HT3 antagonist concurrently with Kynmobi™?	<input type="checkbox"/>	<input type="checkbox"/>	
NEUPRO®			
1. Is the request for Neupro®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member unable to take medications by mouth or is oral therapy clinically inappropriate?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
NOURIANZ™			
1. Is the request for Nourianz™?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will the member be concurrently taking levodopa/carbidopa with Nourianz™ therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
ONGENTYS®			
1. Is the request for Ongentys®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will the member be concurrently taking levodopa/carbidopa with Ongentys® therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

RYTARY®			
1. Is the request for Rytary®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had at least a 3-month trial and failure or contraindication to generic extended-release carbidopa/levodopa?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
TOLCAPONE			
1. Is the request for tolcapone generic tablets?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had a 3-month trial and failure or contraindication/intolerance to entacapone or levodopa/carbidopa/entacapone?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Will the member be concurrently taking levodopa/carbidopa with tolcapone therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
ZELAPAR®			
1. Is the request for Zelapar®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member exhibited deterioration in the quality of their response to levodopa/carbidopa?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member had a trial and failure or contraindication/intolerance to conventional selegiline tablets?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Will the member be concurrently taking levodopa/carbidopa with Zelapar® therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the therapy shown to be effective with a positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	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 Signature:			

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

Policy: PHARM-CHIP-089
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.