HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

PARKINSON'S AGENTS

Apomorphine hydrochloride injection, Duopa™, 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), ☐ 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?	☐	☐	**Please provide documentation**
2. Is the prescriber a neurologist?	☐	☐	
3. Has the member had an inadequate response to oral levodopa/carbidopa therapy?	☐	☐	**Please provide documentation**
APOMORPHINE HYDROCHLORIDE INJECTION			
1. Is the request for apomorphine hydrochloride injection?	☐	☐	
2. Will the member be concurrently taking levodopa/carbidopa with apomorphine hydrochloride injection 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**
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)?	☐	☐	**Please provide documentation**
5. Will the member be taking a 5HT3 antagonist concurrently with apomorphine hydrochloride injection?	☐	☐	

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 MAO-B inhibitor (selegiline)?	☐	☐	**Please provide documentation**
4. 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**
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)?	☐	☐	**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 therapy clinically inappropriate?	☐	☐	**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?	☐	☐	**Please provide documentation**
NOURIANZ™			
1. Is the request for Nourianz™?	☐	☐	
2. Will the member be concurrently taking levodopa/carbidopa with Nourianz™ 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®			
1. 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, pramipexole or ropinirole), COMT inhibitor (entacapone), or MAO-B inhibitor (selegiline)?	☐	☐	**Please provide documentation**

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