Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

APOKYN®

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a diagnosis of advance Parkinson's Disease (PD) with documented hypomobility "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) (documentation must be attached)?

☐ Yes ☐ No

Q2. Is the medication being prescribed in consultation with a specialist (who specializes in the treatment of PD or a neurologist)?

☐ Yes ☐ No

Q3. Does the patient have a history of therapeutic failure, a contraindication to or intolerance of the preferred Antiparkinson's agents (such as carbidopa-levodopa, pramipexole, ropinirole, bromocriptine, amantadine, selegiline, trihexyphenidyl, benztropine, orphenadrine ER, tolcapone) (Must attach documentation)?

☐ Yes ☐ No

Q4. Will the initial "test" dose be given under medical supervision?

☐ Yes ☐ No

Q5. Will the medication ONLY be given via subcutaneous route of administration?

☐ Yes ☐ No

Q6. Will trimethobenzamide be started 3 days prior to the initial dose of Apokyn, and continue as long as necessary to control nausea and vomiting (generally no longer than 2 months)?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. Will this medicine be administered with 5HT3 antagonists (such as ondansetron) to control nausea?	
☐ Yes	☐ No
Q8. Has renal function been evaluated and has medication been dose adjusted for renal impairment, if necessary?	
☐ Yes	☐ No
Q9. Has a cardiac evaluation been performed (including assessment of QTc interval)?	
☐ Yes	☐ No
Q10. Has the patient been counseled on the risks of using alcohol, antihypertensive medications, and vasodilating medications while taking this medication?	
☐ Yes	☐ No
Q11. Will the patient abstain from alcohol while taking this medicine?	
☐ Yes	☐ No
Q12. Is the treatment plan attached showing how the medication will be administered, duration of therapy, and other medications that will be continued?	
☐ Yes	☐ No
Q13. Is each dose less than or equal to 0.6 mL with a dosing frequency of less than or equal to five times per day?	
☐ Yes	☐ No
Q14. Requested Duration:	
☐ 6 Months	
Q15. Additional Information:	

Prescriber Signature

Date

Updated 2018