Apokyn, Kynmobi

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ____________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: __________________________kg

Patient Height: __________________________*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

<u>Drug Information:</u>

Strength/Measure ______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _________________________________ *Route of administration* ________________________
Dosing frequency ______________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Apokyn, Kynmobi SGM - 02/2023.

Criteria Questions:

1. Which drug is being prescribed? ❑ Apokyn ❑ Kynmobi
2. What is the diagnosis?
   ❑ Parkinson's disease ❑ Other ______________________________
3. What is the ICD-10 code? ___________
4. Is the patient currently being treated with carbidopa/levodopa? ❑ Yes ❑ No
5. Is the requested drug prescribed for the acute, intermittent treatment of "off" episodes? ❑ Yes ❑ No
6. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #8*
7. Has the patient experienced improvement in their condition (e.g., reduction in daily "off" time, improvement in motor function post-administration) since starting treatment with the requested drug?
   ❑ Yes ❑ No *No further questions*
8. Does the patient experience at least 1 hour of "off" time per day? ❑ Yes ❑ No
9. Were attempts to manage "off" episodes by adjusting the dosing or formulation of carbidopa/levodopa ineffective?
   ❑ Yes ❑ No
10. Was treatment with carbidopa/levodopa plus one of the following therapies ineffective at managing "off" episodes?
    ❑ Dopamine agonist (e.g., pramipexole, ropinirole)
    ❑ Monoamine oxidase B (MAO-B) inhibitor (e.g., selegiline, rasagiline)
    ❑ Catechol-O-methyl transferase (COMT) inhibitor (e.g., entacapone, tolcapone)
    ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Apokyn, Kynmobi SGM - 02/2023.