Duopa

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:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering 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.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Criteria Questions:

1. What is the diagnosis?

❒ Advanced Parkinson's disease, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

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3. Has the patient demonstrated a positive clinical response with the requested medication?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. Will the requested medication be used for treatment of motor fluctuations in patients with advanced Parkinson's disease?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the patient levodopa responsive with clearly defined "on" periods?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Does the patient have "off" periods greater than 3 hours per day despite optimization efforts?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient had an inadequate response or intolerable adverse event with oral carbidopa/levodopa and one of the following anti-Parkinson agents?

❒ Yes - Dopamine agonist (e.g., pramipexole, ropinirole), *No further questions*

❒ Yes - Monoamine oxidase B (MAO-B) inhibitor (e.g., selegiline, rasagiline), *No further questions*

❒ Yes - Catechol-O-methyl transferase (COMT) inhibitor (e.g., entacapone, tolcapone), *No further questions*

❒ No - None of the above, *No further questions*

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

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org