Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Apokyn™ (apomorphine)

Member Name:	DOB:	Date:
Medicaid ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	
Requested Dose/Directions:		

Please complete below information for applicable situation,* Initiation *or* Continuation *of therapy:

☐ **INITIATION OF THERAPY: Member must meet all of the following criteria:**

1. Medication is being prescribed by, or in consult with, a neurologist: ☐ Yes ☐ No

   Action Required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of Specialist: _____ Contact Date: _____

2. Member has a diagnosis of advanced Parkinson's disease: ☐ Yes ☐ No

3. Member is experiencing "off" episodes (return of Parkinson's symptoms) while receiving a carbidopa/levodopa regimen where:

   ☐ Attempts have been made to adjust the carbidopa/levodopa's dose and/or formulation to manage symptoms without success

   ☐ Provider attests to discussing dietary intake with member to optimize the effects of the carbidopa/levodopa

   ☐ Member will continue carbidopa/levodopa in combination with Apokyn

4. Member has had previous, inadequate responses to or has been intolerant of at least ONE different class of medications for the treatment of Parkinson's disease (e.g., monoamine oxidase type B [MAO-B] inhibitors, dopamine agonists, catechol-O-methyl transferase [COMT] inhibitors, etc), unless contraindicated:

   Drug Name/Class: _____ Dates of use: _____

5. Is member taking a 5-HT3 antagoinist (i.e., ondansetron, granisetron, dolasetron, palonosetron or alosetron)?

   ☐ Yes ☐ No

   If answered Yes, therapy will not be approved.

LIMITATIONS: Maximum dose allowed is 1.8mL per day.

Initial authorization will be granted for six months.

☐ **CONTINUATION OF THERAPY:**

1. Provider must provide documentation showing stabliziation of disease or absence of disease progression AND absence of unacceptable toxicity from drug.
2. Annual specialist consult is **attached**, if prescriber is not a specialist. ☐ Yes ☐ No ☐ N/A - Prescriber is specialist.

Reauthorization will be issued for one year.

Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350.

9/2021