

**Montana Healthcare Programs Prior Authorization Request Form for Use of
Kynmobi (apomorphine HCl)**

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, information on annual consult with an appropriate specialist is required:

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 in order 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 Kynmobi

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 antagonist (i.e. ondansetron, granisetron, dolasetron, palonosetron, or alosetron)?

☐ Yes ☐ No

If answered Yes, therapy will not be approved.

LIMITATIONS: #150 sublingual films per 30 days

Initial authorization will be granted for 6 months.

☐ CONTINUATION OF THERAPY:

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

Reauthorization will be issued for 1 year.

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

7/2021