OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: (Select drug below)

❑ **Apokyn®** (apomorphine hydrochloride) **subcutaneous injection**	❑ **Kynmobi™** (apomorphine hydrochloride) **sublingual film**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Recommended Dosage:

- **Apokyn:** Initial dose is 0.2 mL (2 mg) gradually titrated and required under medical supervision; Maximum recommended dose is 0.6 mL (6mg). Quantity Limit: 6 boxes (90mL) per month.
- **Kynmobi:** Initial dose is 10mg as needed at intervals of 2 hours or greater up to a maximum of 5 doses per day; Maximum single dose of 30mg max of 5 doses per day. Quantity Limit: 150 tablets/30 days.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

❑ Member must be 18 years of age or older

AND

❑ **If requesting Apokyn®:** member has had an unsuccessful 30 day trial of *Inbrija™, *Nourianz™ AND ***Kynmobi** (*require prior authorization – see www.optimahealth.com for prior authorization form; chart notes must be submitted to document medication failures)

OR

❑ **If requesting Kynmobi™:** member has had an unsuccessful 30 day trial of *Nourianz™ (*require prior authorization – see www.optimahealth.com for prior authorization form; chart notes must be submitted to document medication failures)

AND

All criteria must be met below for Apokyn® and Kynmobi™:

❑ Medication must be prescribed by, or in consultation with a neurologist

AND

(Continued on next page)

- ❑ Member must have a confirmed diagnosis of Parkinson's disease in an individual who is having intermittent OFF episodes while on continuous carbidopa/levodopa therapy and all of the following criteria has been met: **(must submit chart notes)**
  - ❑ Provider have made adjustments to adjust the carbidopa/levodopa dose in order to manage symptoms without success

AND

  - ❑ Member is receiving concurrent therapy with carbidopa/levodopa **within the past 30 days AND** will be used in combination with continuous carbidopa/levodopa treatment

AND

- ❑ Member has had previous inadequate responses to or has been intolerant of at least **TWO** different classes of medications for the treatment of Parkinson's disease (e.g. monoamine oxidase type B inhibitor dopamine agonist, or COMT inhibitor

AND

- ❑ Member must be started on an anti-emetic 3 days prior to beginning treatment. Trimethobenzamide is the only antiemetic that has been studied and can be used with apomorphine

AND

- ❑ Member is currently not taking a 5-HT3 antagonist such as Zofran (ondansetron), Kytril (granisetron), Aloxi (palonostron), Lotronex (alosetron), or Anzemet (dolasetron) which can result in profound hypotension and loss of consciousness **(pharmacy claims will be verified)**

AND

- ❑ Member has received a starting dose and did not develop clinically significant orthostatic hypotension

AND

- ❑ Member does not have hypersensitivity to apomorphine, any of its components or sulfa allergy

Reauthorization approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Must submit chart notes documenting a positive clinical response to therapy (e.g. continued success at reversing off-episodes, improved motor function)

AND

- ❑ Member continues to meet all initial criteria and has an absence of drug toxicity

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: ~~11/21/2019; 10/16/2020~~
REVISED/UPDATED: ~~2/3/2020; 11/2/2020;~~ **10/11/2021**;