SENTARA COMMUNITY PLAN
(MEDICAID)

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 can be delayed.**

Apomorphine Products

Drug Requested: (Select drug below)

❑ **Apokyn®** (apomorphine hydrochloride) **subcutaneous injection**	❑ **apomorphine hydrochloride subcutaneous injection**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage:

- **Apokyn or apomorphine hydrochloride:** 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.

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: 12 months

(Continued on next page)

- ❑ Member must be 18 years of age or older
- ❑ Medication must be prescribed by, or in consultation with a neurologist
- ❑ Member is receiving concurrent therapy with carbidopa/levodopa **within the past 30 days AND** requested medication will be used in combination with continuous carbidopa/levodopa treatment **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Provider has made adjustments to members carbidopa/levodopa dose in order to manage symptoms without success
- ❑ Member is **NOT** currently taking a 5-HT3 antagonist medication such as Zofran® (ondansetron), Kytril® (granisetron), Aloxi® (palonostron), Lotronex® (alosetron), or Anzemet® (dolasetron) which can result in profound hypotension and loss of consciousness **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Member has received a starting dose of requested medication and did **NOT** develop clinically significant orthostatic hypotension
- ❑ Member does **NOT** have hypersensitivity to apomorphine, its excipients or sodium metabisulfite
- ❑ Member must meet all applicable medication specific criteria below

For Apokyn® and apomorphine hydrochloride requests: All clinical criteria MUST be met

- ❑ 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
- ❑ 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) **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Member has had an unsuccessful 30-day trial of *Inbrija™ **AND** *Nourianz™ **(*both prerequisite drug therapies require prior authorization – see www.sentarahealthplans.com for prior authorization form; chart notes must be submitted to document medication failures)**

Reauthorization: 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.

- ❑ Provider must submit chart notes confirming a positive clinical response to therapy, such as continued success in reversing "OFF" episodes, improved motor function, or clinically significant improvement or stabilization in the signs and symptoms of the disease
- ❑ Member continues to meet all initial criteria and has an absence of drug toxicity

Medication being provided by Specialty Pharmacy - PropriumRx

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.*

***Approved by Pharmacy and Therapeutics Committee**: ~~11/21/2019; 10/16/2020; 5/22/2025;~~ **11/20/2025**
REVISED/UPDATED/REFORMATTED: ~~2/3/2020; 11/2/2020; 10/11/2021. 6/09/2025, 12/12/2025;~~ **6/26/2026**