

SENTARA HEALTH PLANS

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.**

Drug Requested: Duopa (carbidopa and levodopa enteral suspension) (**Pharmacy**)

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: The maximum recommended daily dosage is 2,000 mg of the levodopa component (one cassette, 100 mL per day) administered over 16 hours

Quantity Limit: 4 cartons (3000 billable units) every 28 days; 1 billable unit =100 mL

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

- Prescribed by or in consultation with a neurologist
- Member is 18 years of age or older
- Member has a diagnosis of advanced Parkinson's disease (PD) with complicated motor fluctuations
- Member does **NOT** have a diagnosis of atypical PD or secondary PD
- Requested medication will be administered via a percutaneous endoscopic gastrostomy with jejunal tube (PEG-J) or naso-jejunal tube

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- Member is experiencing “off” episodes such as muscle stiffness, slow movements, or difficulty starting movements
- Provider has submitted documentation which confirm member’s symptoms have **NOT** been adequately controlled with optimal medical therapy using **ALL** the following agents:
 - An oral extended-release carbidopa-levodopa therapy
 - Dopamine agonist (e.g., Apokyn[®], Neupro[®], pramipexole, ropinirole)
 - ONE** agent from any of the following classes:
 - Catechol-0-methyl transferase (COMT) inhibitor (e.g., entacapone, Ongentys[®], tolcapone)
 - Monoamine oxidase B (MAO-B) inhibitor (e.g., rasagiline, selegiline, Xadago[®])
 - Adenosine receptor antagonist (e.g., Nourianz[®])
- Member is **NOT** currently taking a nonselective MAO inhibitor (such as phenelzine or tranylcypromine)

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.

- Member continues to meet all initial authorization criteria
- Provider has submitted documentation which confirms member has experienced clinically significant improvement or stabilization in clinical signs and symptoms of disease

Medication being provided by a Specialty Pharmacy – Proprium Rx

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.****