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: Antiparkinson Agents

❑ **Inbrija™** (levodopa inhalation powder)	❑ **Nourianz™** (istradefylline)
❑ **Ongentys®** (opicapone)	❑ **tolcapone**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

RECOMMENDED DOSAGE:

- **Inbrija™:** Oral inhalation: 84 mg up to 5 times daily as needed when symptoms of an OFF period return. Maximum quantity limit: 84 mg/dose and 420 mg/day.
- **Nourianz™:** Oral: 20 mg once daily; may further increase dose based on response and tolerability to a maximum dose of 40 mg once daily. Maximum quantity limit: 30 tablets /30 days
- **Ongentys®:** Oral: 50 mg once daily at bedtime. Maximum quantity limit: 30 tablets/30 days.
- **tolcapone:** Oral: Initial: 100 mg 3 times daily always as an adjunct to levodopa/carbidopa; may increase as tolerated to 200 mg 3 times daily. Maximum quantity limit: 180 tablets/30days

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 Approval: 6 months

❑ Member must be 18 years of age or older

AND

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

AND

❑ 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 has made adjustments to adjust the carbidopa/levodopa's dose in order to manage symptoms without success

AND

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

AND

- ❑ **For ALL Antiparkinson Agents**, member is currently not taking or has not recently (within 2 weeks) taken a nonselective MAO inhibitor such as Nardil® (phenelzine), Parnate® (tranylcypromine), or Marplan® (isocarboxazid

❑ **For generic tolcapone**. 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 must have documentation of trial and failure of **TWO (2)** of the following:
  - ❑ COMT inhibitor: generic entacapone

AND

  - ❑ Dopamine agonist: ropinirole/ropinirole ER, pramipexole/pramipexole ER; **OR**
  - ❑ Monoamine oxidase type B inhibitors: rasagiline; **OR**
  - ❑ Ongentys® (opicapone) requires prior authorization; **OR**

AND

- ❑ Provider attestation to monitor for liver failure/hepatic dysfunction and should discontinue tolcapone if ALT/AST levels exceed 2 times the upper limit of normal

❑ **For Ongentys®.** 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 must have documentation of trial and failure of **TWO (2)** of the following:
  - ❑ COMT inhibitor: generic entacapone

AND

  - ❑ Dopamine agonist: ropinirole/ropinirole ER, pramipexole/pramipexole ER; **OR**
  - ❑ Monoamine oxidase type B inhibitors: rasagiline; **OR**

AND

- ❑ Member does not have a history of pheochromocytoma, paraganglioma, or other catecholamine-secreting neoplasms

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❑ **For Inbrija® or Nourianz®,** 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 must have documentation of trial and failure of **TWO (2)** of the following:
  - ❑ Monoamine oxidase type B inhibitors: rasagiline; **OR**
  - ❑ Dopamine agonist: ropinirole/ropinirole ER, pramipexole/pramipexole ER; **OR**
  - ❑ COMT inhibitor: generic entacapone, Ongentys® (requires prior authorization), tolcapone (requires prior authorization)

AND

- ❑ Member does not have a history of asthma, COPD, or other chronic underlying lung disease **(for Inbrija™ only)**

❑ **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.

- ❑ Member must continue to meet initial approval criteria

AND

- ❑ Member has a documented positive clinical response to treatment (defined as: improvement and stabilization of "off episodes" associated with Parkinson's disease)

AND

- ❑ Medication is used in combination with carbidopa/levodopa **(must have pharmacy paid claims)**

AND

- ❑ Member must be absent of unacceptable toxicity from therapy

Medication being provided by Specialty Pharmacy - PropriumRx

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(Please ensure signature page is attached to form.)

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 pha rmacy paid claims or submitted chart notes.****

Member 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**: ~~9/20/2019;~~ 2/20/2020
REVISED/UPDATED: ~~10/8/2019; 6/11/2020; 4/1/2021;~~ **6/14/2021** ;