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.**

Drug Requested: Vyalev™ (foscarbidopa and foslevodopa subcutaneous injection) **(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 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 3,525 mg of the foslevodopa component (equivalent to approximately 2,500 mg levodopa)

Quantity Limit: 6 cartons every 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: 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
- ❑ Member is experiencing "off" episodes such as muscle stiffness, slow movements, or difficulty starting movements

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- ❑ Provider has submitted documentation which confirms 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

*****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: 1/23/2025**
REVISED/UPDATED/REFORMATTED: 02/18/2025