carolina complete health

Pharmacy Prior Approval Request for

# Antiparkinson's Agents-Inbrija and Ongentys

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ___

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

**Clinical Information**

**Inbrija - initial authorization requests** ****Initial requests can be approved for up 6 months**:**
1. Is the beneficiary age 18 or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of Parkinson's Disease and is experiencing "off" episodes? ☐ **Yes** ☐ **No**
3. Will the beneficiary be concurrently receiving optimized carbidopa/levodopa therapy? ☐ **Yes** ☐ **No**
4. Is the beneficiary currently taking a nonselective monoamine (MAO) inhibitor or has the beneficiary taken a MAO inhibitor within the last two weeks? ☐ Yes ☐ No
5. Does the beneficiary have asthma, COPD or other chronic lung disease? ☐ Yes ☐ No

**Inbrija - reauthorization requests (please answer questions 1-6)** ****Reauthorization requests can be approved for up to 12 months**:**
6. Has documentation been submitted that indicates the beneficiary has had an improvement in their symptoms from baseline? ☐ **Yes** ☐ **No**

**Ongentys - initial authorization requests** ****Initial requests can be approved for up 6 months**:**
7. Is the beneficiary age 18 years of age or older? ☐ **Yes** ☐ **No**
8. Does the beneficiary have a diagnosis of Parkinson's Disease and is experiencing "off" episodes for at least 1.5 hours/day on average? ☐ **Yes** ☐ **No**
9. Does the beneficiary have no contraindications including ESRD (creatinine clearance <15 ml/min/1.73m2)? ☐ **Yes** ☐ **No**
10. Does the beneficiary have no contraindications including severe hepatic impairment (Child-Pugh C)? ☐ **Yes** ☐ **No**
11. Is the beneficiary currently taking a nonselective monoamine oxidase-B (MAO-B) inhibitor? ☐ **Yes** ☐ **No**
12. Will the beneficiary be concurrently receiving optimized carbidopa/levodopa therapy? ☐ **Yes** ☐ **No**
13. Has the beneficiary had an adequate trial and subsequent failure of at least 2 preferred adjunctive therapies (e.g., dopamine agonists, MAO-B inhibitors, catechol-O-methyltransferase [COMT] inhibitors) to control "off" symptoms? ☐ **Yes** ☐ **No**

**Ongentys - reauthorization requests (please answer questions 7-15)** ****Reauthorization requests can be approved for up to 12 months**:**
14. Has documentation been submitted that indicates the beneficiary has had clinically meaningful response to treatment (e.g., beneficiary shows a reduction in time of "off" episodes)? ☐ **Yes** ☐ **No**
15. Has the beneficiary experienced toxicity or treatment related adverse event from the drug (e.g., dyskinesias, hallucinations/psychotic behavior, impulse control/compulsive behaviors)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/

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