Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Apomorphine

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a renewal request? If YES, go to 15. If NO, go to 2.

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of advanced Parkinson's Disease (PD) with documented hypomobility "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) (documentation must be attached)?

☐ Yes ☐ No

Q3. Is the medication being prescribed by or in consultation with a specialist (who specializes in the treatment of PD or a neurologist)?

☐ Yes ☐ No

Q4. Is there documentation of an inadequate response, intolerance, or contraindication to conventional oral therapies(such as carbidopa-levodopa, pramipexole, ropinirole, bromocriptine, amantadine, selegiline, trihexyphenidyl, benztropine, entacapone, tolcapone) (Must attach documentation)?

☐ Yes ☐ No

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Apomorphine

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q5. Will the initial "test" dose be given under medical supervision?

☐ Yes ☐ No

Q6. Will the medication ONLY be given via subcutaneous route of administration?

☐ Yes ☐ No

Q7. Will trimethobenzamide be started 3 days prior to the initial dose of Apokyn, and continue as long as necessary to control nausea and vomiting (generally no longer than 2 months)?

☐ Yes ☐ No

Q8. Will this medicine be administered with 5HT3 antagonists (such as ondansetron) to control nausea?

☐ Yes ☐ No

Q9. Has renal function been evaluated and has medication been dose adjusted for renal impairment, if necessary?

☐ Yes ☐ No

Q10. Has a cardiac evaluation been performed (including assessment of QTc interval)?

☐ Yes ☐ No

Q11. Has the patient been counseled on the risks of using alcohol, antihypertensive medications, and vasodilating medications while taking this medication?

☐ Yes ☐ No

Q12. Will the patient abstain from alcohol while taking this medicine?

☐ Yes ☐ No

Q13. Is the treatment plan attached showing how the medication will be administered, duration of therapy, and other medications that will be continued?

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Apomorphine

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q14. Is each dose less than or equal to 0.6 mL with a dosing frequency of less than or equal to five times per day?

☐ Yes ☐ No

Q15. Does the patient continue to need Apokyn® and meet the criteria identified for initial approval?

☐ Yes ☐ No

Q16. Does the patient tolerate the medication without significant or serious side effects (must attach documentation)?

☐ Yes ☐ No

Q17. Has the patient had an improvement in symptoms from baseline (must attach documentation)?

☐ Yes ☐ No

Q18. Is there documentation of a treatment plan including duration of treatment (must attach documentation)?

☐ Yes ☐ No

Q19. Additional Information:

_____ _____

Prescriber Signature Date

v2025