Part B Prior Authorization Guidelines

Dopamine Agonists:

Apokyn / Kynmobi (apomorphine) J0364

Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested ________________		
	Requestor _________________ Clinic name: ________________ Phone / Fax		

MEMBER INFORMATION

*Name:______________________________ *ID#:__________________ *DOB:__________________

PRESCRIBER INFORMATION

*Name:____________________________ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:__________________

*Address:____ *Fax:____________________

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____________________________ Phone:_______________________

*Address:____ Fax:_________________________

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:______)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**____

Diagnosis: ICD10: ________ **Description**: ____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: ________________________________

____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ Patient had an <u>adequate response</u> or <u>significant improvement</u> while on this medication.

If not, please provide clinical rationale for continuing this medication: ____________________________

____

ACKNOWLEDGEMENT

Request By (Signature Required): ____________________________________Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Dopamine Agonist PA

Drug Name(s):
APOKYN
KYNMOBI
APOMORPHINE

Criteria for approval of Prior Authorization Drug:
1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Approvals will be for 12 months

FDA Indications:
Apokyn, Kynmobi
- Parkinson's disease, Acute, intermittent treatment of hypomobility "off" episodes

Off-Label Uses:
- Erectile dysfunction
- Induction of emesis, For treatment of acute poisoning
- Parkinsonism; Diagnosis

Age Restrictions:
Safety and effectiveness have not been established in pediatric patients

Other Clinical Considerations:
CI: Concomitant use with serotonin 5-hydroxytryptamine-3 (5-HT(3)) receptor antagonists including antiemetics

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/CS/908395/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/DECC9E/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=apomorphine#