Apokyn, Kynmobi

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

1. Which drug is being prescribed? ❑ Apokyn ❑ Kynmobi
2. What is the diagnosis?
   ❑ Parkinson's disease
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Is the product being requested for the treatment of Parkinson's disease? ❑ Yes ❑ No *If No, skip to #9*
5. The preferred product for your patient's health plan is Inbrija Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*** ❑ Yes ❑ No
6. Does the patient have a documented inadequate response to treatment with the preferred product (Inbrija)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s) and skip to #9.*** ❑ Yes ❑ No
7. Does the patient have a documented intolerable adverse event to the preferred product (Inbrija)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s) and skip to #9.*** ❑ Yes ❑ No
8. Does the patient have a documented contraindication to the preferred product (Inbrija)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No
9. Is the patient currently being treated with carbidopa/levodopa? ❑ Yes ❑ No
10. Is the requested drug prescribed for the acute, intermittent treatment of "off" episodes? ❑ Yes ❑ No
11. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #13*
12. Has the patient experienced improvement in their condition (e.g., reduction in daily off time, improvement in motor function post-administration) since starting treatment with the requested drug?
    ❑ Yes ❑ No *No further questions*
13. Does the patient experience at least 2 hours of off time per day? ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

14. Were attempts to manage off episodes by adjusting the dosing or formulation of carbidopa/levodopa ineffective?
❑ Yes ❑ No

15. Was treatment with carbidopa/levodopa plus one of the following therapies ineffective at managing off episodes?
❑ Dopamine agonist (e.g., pramipexole, ropinirole)
❑ Monoamine oxidase B (MAO-B) inhibitor (e.g., selegiline, rasagiline)
❑ Catechol-O-methyl transferase (COMT) inhibitor (e.g., entacapone, tolcapone)
❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?
❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Inbrija) FDA-approved for the medical condition being treated?
❑ Yes ❑ No *If No, no further questions.*

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Inbrija)?
If yes, indicate below and no further questions.
❑ The alternate drug is contraindicated
❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
❑ The alternate drug is expected to be ineffective
❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
❑ The alternate drug is not in the patient's best interest
❑ The alternate drug was tried while covered by the current or the previous health benefit plan
❑ *None of the above, continue to #8*

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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