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 request for reauthorization? If YES, go to question 2. If NO, go to question 4.

☐ Yes ☐ No

Q2. Does the patient continue to need apomorphine and meet criteria identified for initial approval? If YES, go to question 3

☐ Yes ☐ No

Q3. Has the patient had an improvement in symptoms from baseline? (Chart notes must be attached). If YES, go to question 7.

☐ Yes ☐ No

Q4. 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)? (Chart notes must be attached). If YES, go to question 5.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Is the patient currently on a stable dose of carbidopa/levodopa, and will the patient continue taking carbidopa/levodopa with apomorphine? (Documentation must be attached). If YES, go to question 6.

☐ Yes ☐ No

Q6. Is there documentation of an inadequate response, intolerance, or contraindication to carbidopa/levodopa in addition to one drug from two different classes of adjunctive oral therapies (such as pramipexole, ropinirole, bromocriptine, entacapone, tolcapone, selegiline, rasagiline, amantadine, trihexyphenidyl, benztropine)? (Documentation must be attached). If YES, go to question 7.

☐ Yes ☐ No

Q7. Is the medication being prescribed by or in consultation with a specialist who specializes in the treatment of Parkinson's disease (PD) or a neurologist? If YES, go to question 8.

☐ Yes ☐ No

Q8. Is this a request for a formulary product? If NO, go to question 9

☐ Yes ☐ No

Q9. Is there documentation of an inadequate response, intolerance, or contraindication to all formulary products indicated for the diagnosis that would not be expected to occur with requested agent?

☐ Yes ☐ No

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2026

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