



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Apomorphine - Non-PDL

Phone: 866-841-7659

Fax back to: 866-240-3712

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.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP		Specialty Pharmacy (if applicable):	
Drug Name:		Strength:	
Quantity:		Refills:	
Directions:			
Diagnosis Code:		Diagnosis:	
Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..			

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 Q6. If no, go to Q2

☐ 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)? (Chart notes must be attached).

☐ Yes

☐ No

Q3. 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)?

☐ Yes

☐ No

Q4. 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).

☐ Yes

☐ No

Q5. 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



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(such as pramipexole, ropinirole, bromocriptine, entacapone, tolcapone, selegiline, rasagiline, amantadine, trihexyphenidyl, benzotropine)? (Documentation must be attached).

☐ Yes ☐ No

Q6. FOR RENEWAL: Does the patient continue to need apomorphine and meet the criteria identified for initial approval?

☐ Yes ☐ No

Q7. Has the patient had an improvement in symptoms from baseline? (Documentation must be attached).

☐ Yes ☐ No

Q8. Additional Information:

Prescriber Signature

Date

v2026-06