Kynmobi (apomorphine)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Parkinson's Disease ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No

Is Kynmobi being prescribed by or in consulatation with a neurologist? ☐ Yes ☐ No

Is patient's Parkinson's disease idiopathic? ☐ Yes ☐ No

Does patient have atypical or secondary parkinsonism? ☐ Yes ☐ No

Has patient been stable on their current Parkinson's medication for at least 30 days? ☐ Yes ☐ No

Is patient experiencing at least one well defined "OFF" episode per day during the waking day? ☐ Yes ☐ No ***Please submit chart notes.***

Is patient experiencing a TOTAL daily "OFF" time duration EXCEEDING 2 hours per day during the waking day? ☐ Yes ☐ No ***Please submit chart notes.***

Is patient physically independent when in the "ON" state? ☐ Yes ☐ No

Has patient had previous treatment with any form of a continuous subcutaneous apomorphine infusion, any neurosurgical procedure for Parkinson's disease or use of Duodopa/Duopa? ☐ Yes ☐ No

Does patient have a history of malignant melanoma? ☐ Yes ☐ No

Does patient have a history of clinically significant hallucinations during the past 6 months? ☐ Yes ☐ No

Has the patient had a prior use of Ongentys(opicapone)? ☐ Yes ☐ No

Has the patient had prior use of Inbrija(levodopa inhalation)? ☐ Yes ☐ No

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If patient has not had prior use of Inbrija, do they have one of the below contraindications?
Please check one of the following:

- □ **Patient is age 20-29 years**
- □ **Patient's Parkinson's disease is SEVERE during "ON" periods**
- □ **Patient is NOT fully independent in activities of daily living during "ON" periods**
- □ **Patient has been treated for asthma, COPD or another CHRONIC respiratory disease within the past 5 years**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811