

Nourianz (istradefylline)
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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Other diagnosis: _____ ICD-10: _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Clinical Information: Does the patient have a confirmed diagnosis of Parkinson's Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i> Does the patient have bilateral involvement when in the OFF state? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient wheelchair bound? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient experiencing, on average, at least 2 hours of daily OFF time per waking day, not including early morning OFF time? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been treated with levodopa/carbidopa for at least the past 1 year? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the patient be continuing on levodopa therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient previously received any neurosurgical procedure for Parkinson's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication being prescribed by, or in consultation with, a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior use of Ongentys(opicapone)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior use of Inbrija(levodopa inhalation)? <input type="checkbox"/> Yes <input type="checkbox"/> No If patient has not had prior use of Inbrija, do they have one of the below contraindications? <i>Please check one of the following:</i> <input type="checkbox"/> Patient is age 20-29 years <input type="checkbox"/> Patient's Parkinson's disease is SEVERE during "ON" periods <input type="checkbox"/> Patient is NOT fully independent in activities of daily living during "ON" periods <input type="checkbox"/> 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? <hr/> <hr/>		
<p>*Please note: Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.</p>		

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

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:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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