AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Inbrija and Ongentys

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Inbrija – Initial authorization requests: **Initial requests can be approved for up to 6 months.**

1. Is the beneficiary age 18 or older? Yes___ No___
2. Does the beneficiary have a diagnosis of Parkinson's Disease and is experiencing "off" episodes? Yes___ No___
3. Will the beneficiary be concurrently receiving optimized carbidopa/levodopa therapy? Yes___ No___
4. Is the beneficiary currently taking a nonselective monoamine (MAO) inhibitor or has the beneficiary taken a MAO inhibitor within the last two weeks? Yes___ No___
5. Does the beneficiary have asthma, COPD or other chronic lung disease? Yes___ No___

Inbrija – Reauthorization requests (answer questions 1-6): **Reauthorization requests can be approved for up to 12 months**

6. Has documentation been submitted that indicates the beneficiary has had an improvement in their symptoms from baseline? Yes___ No___

Ongentys – Initial authorization requests: **Initial requests can be approved for up 6 months**

7. Is the beneficiary 18 years of age or older? Yes___ No___
8. Does the beneficiary have a diagnosis of Parkinson's Disease and is experiencing "off" episodes for at least 1.5 hours/day on average? Yes___ No___
9. Does the beneficiary have no contraindications including ESRD (creatinine clearance <15 ml/min/1.73m2)? Yes___ No___
10. Does the beneficiary have no contraindications including severe hepatic impairment (Child-Pugh C)? Yes___ No___
11. Is the beneficiary currently taking a nonselective monoamine oxidase-B (MAO-B) inhibitor? Yes___ No___
12. Will the beneficiary be concurrently receiving optimized carbidopa/levodopa therapy? Yes___ No___
13. Has the beneficiary had an adequate trial and subsequent failure of at least 2 preferred adjunctive therapies (e.g., dopamine agonists, MAO-B inhibitors, catechol-O-methyltransferase [COMT] inhibitors) to control "off" symptoms? Yes___ No___

Ongentys - Reauthorization requests (answer questions 7-15): **Reauthorization requests can be approved for up to 12 months**

14. Has documentation been submitted that indicates the beneficiary has had clinically meaningful response to treatment (e.g., beneficiary shows a reduction in time of "off" episodes)? Yes___ No___
15. Has the beneficiary experienced toxicity or treatment related adverse event from the drug (e.g., dyskinesias, hallucinations/psychotic behavior, impulse control/compulsive behaviors)? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406