

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Apomorphine Injection - Medicare

Fax back to: 866-371-3239 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 re

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Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
he life or health of the enrollee or the enrollee's ability to regain maximum func	certify that applying the 72 hour standard review timeframe may seriously jeopardize tion.
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. Does the patient have a documented diagn off episodes?	osis of Parkinson's disease (PD) with intermittent
☐ Yes	□ No
Q2. Is Apomorphine hydrochloride injection being prescribed by or in consultation with a neurologist?	
□Yes	□ No
Q3. Is there documentation of an inadequate response, intolerance, or contraindication to at least two conventional oral therapies (e.g carbidopa-levodopa, pramipexole, ropinirole, bromocriptine, amantadine, selegiline, rasagaline, trihexyphenidyl, benztropine, entacapone, tolcapone)?	
☐ Yes	□ No
Q4. Additional Information:	
Q5. Requested Duration:	
☐ 12 months	☐ Other

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Patient Name:	Prescriber Name:
Prescriber Signature	Date
	2024 Medicare Prior Authorization Request