



# 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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://magellanrx.com/member/external/commercial/common/doc/en-us/phi_disclosure_authorization.pdf)

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?**  YES (if yes, complete below)  NO

<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>	<b>DURATION OF THERAPY (SPECIFY DATES):</b>	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>

**2. LIST DIAGNOSES:** **ICD-10:**

<input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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**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 consultation 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:** \_\_\_\_\_

**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:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

