BlueCross BlueShield of North Carolina

Agents for Parkinson's Disease– NC Standard

Nourianz™; Ongentys®; Xadago®

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP

PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER
			M F

Diagnosis Code: _____

PLEASE SELECT THE REQUESTED MEDICATION AND ANSWER THE FOLLOWING QUESTIONS:

☐ Nourianz ☐ Ongentys ☐ Xadago

1. Does the patient have a diagnosis of Parkinson's disease?.....☐ Yes ☐ No
2. Is the patient currently on carbidopa/levodopa therapy without titration for the past 30 days?...☐ Yes ☐ No
3. Is the patient experiencing "off" or breakthrough episodes of motor dysfunction that cannot be further managed through the titration of current therapy?.....☐ Yes ☐ No
4. Has the patient tried and failed or has an intolerance/contraindication to mononamine oxidase Type B inhibitors (MAOB-I) (ex. selegiline, rasagiline) other than safinamide (Xadago)?.....☐ Yes ☐ No
5. Has the patient tried and failed or has an intolerance to catachol-O-methyl transferase inhibitors (COMT-I) (ex. entacapone)? .....☐ Yes ☐ No
6. Please list additional medications the patient has tried and failed, or has a contraindication/intolerance to *(omission of information indicates N/A or none):* _____
   _____

****NOTE: If requesting a quantity of over 1 tablet/capsule daily of Nourianz, Ongentys, or Xadago, please complete* ***page 2********

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403

BlueCross BlueShield of North Carolina

COMPLETE PAGE 2 ONLY IF REQUESTING A QUANTITY LIMIT EXCEPTION FOR NOURIANZ, ONGENTYS, OR XADAGO

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]
CONTACT PERSON	**PRESCRIBER PHONE**	**PRESCRIBER FAX**
PRESCRIBER ADDRESS	**CITY**	**STATE** / **ZIP**
PATIENT NAME	**Blue Cross NC ID**	**DATE OF BIRTH** / **GENDER**
		M F

FOR COVERAGE OVER THE QUANTITY LIMITS (PROGRAM MAXIMUM PER DAY) LISTED BELOW, PLEASE ANSWER THE FOLLOWING:

Please note: *This medication requires a* ***prior authorization*** *before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will deny.*

Diagnosis Code:_____

Medication	Quantity per Day
Nourianz (istradefylline) 20mg, 40mg	1 tablet
Ongentys (opicapone) 25mg, 50mg	1 capsule
Xadago (safinamide) 50mg, 100mg	1 tablet

Medication Name and Strength: _____ **Requested Quantity per day:** _____

****Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records). **Rationale must be submitted.**

_____

_____

_____

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-800-795-9403