PARKINSON'S DISEASE
PRIOR AUTHORIZATION / MEDICAL NECESSITY DETERMINATION
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. Start saving time today by filling out this prior authorization form electronically. Visit www.NaviNet.net/hzdpa to register and then begin using this free service as part of your existing NaviNet account.

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:		Patient Telephone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient diagnosis (ICD code and description)**:**

Medication requested: Strength:

Dosing schedule: Quantity per month:

All requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
2. Has the patient tried a generic levodopa/carbidopa agent within the past 90 days (medication samples will not be considered a trial)? ☐ Yes ☐ No
3. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested diagnosis, or does the requested agent NOT have a maximum FDA labeled dose for the requested diagnosis? ☐ Yes ☐ No
   If yes, please provide information to support therapy with a higher quantity (dose) for the requested diagnosis: _____
   _____
   If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit? ☐ Yes ☐ No
   If no, please explain why the requested dose cannot be optimized: _____
   _____

Ongentys requests:

4. Are there medical records showing the patient tried generic entacapone within the past 90 days (medication samples will not be considered a trial)? **Medical records are required.** ☐ Yes ☐ No
   If no, is there a MedWatch form (http://fda.gov/media/76299/download) showing the patient has an intolerance or hypersensitivity to entacapone? **MedWatch form is required.** ☐ Yes ☐ No
   If no, are there medical records showing the patient has an FDA labeled contraindication to entacapone? **Medical records are required.** ☐ Yes ☐ No

Please fax or mail this form to:
Horizon Blue Cross Blue Shield of New Jersey
c/o Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
Fax: 877.897.8808 Phone: 888.214.1784

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 888.214.1784, and return the original message to Horizon Blue Cross Blue Shield of New Jersey c/o Prime Therapeutics via U.S. Mail. Thank you for your cooperation.

©PRIME THERAPEUTICS LLC 05/23