

ANTIPARKINSON'S AGENTS PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Antiparkinson's Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antiparkinson's Agents** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:	<input type="checkbox"/> Azilect tablet <input type="checkbox"/> amantadine <u>tablet</u> <input type="checkbox"/> carbidopa tablet <input type="checkbox"/> carbidopa/levodopa <u>ODT</u> <input type="checkbox"/> Comtan tablet <input type="checkbox"/> Duopa suspension <input type="checkbox"/> entacapone tablet <input type="checkbox"/> Lodosyn tablet <input type="checkbox"/> Mirapex tablet	<input type="checkbox"/> Mirapex ER tablet <input type="checkbox"/> Neupro patch <input type="checkbox"/> Parlodel capsule <input type="checkbox"/> Parlodel tablet <input type="checkbox"/> pramipexole ER tablet <input type="checkbox"/> Requip tablet <input type="checkbox"/> Requip XL tablet <input type="checkbox"/> ropinirole <u>ER</u> tablet	<input type="checkbox"/> Rytary ER capsule <input type="checkbox"/> Sinemet tablet <input type="checkbox"/> Sinemet CR tablet <input type="checkbox"/> Stalevo tablet <input type="checkbox"/> Tasmar tablet <input type="checkbox"/> tolcapone tablet <input type="checkbox"/> Zelapar ODT <input type="checkbox"/> _____
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Antiparkinson's Agents? <i>Check all that apply.</i> <input type="checkbox"/> amantadine <u>capsule</u> or solution <input type="checkbox"/> benzotropine tablet <input type="checkbox"/> bromocriptine tablet <input type="checkbox"/> carbidopa/levodopa <u>IR or ER</u> tablet <input type="checkbox"/> carbidopa/levodopa/entacapone tablet		<input type="checkbox"/> pramipexole <u>IR</u> tablet <input type="checkbox"/> ropinirole <u>IR</u> tablet <input type="checkbox"/> selegiline capsule or tablet <input type="checkbox"/> trihexyphenidyl tablet or elixir <input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances</u> <input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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