Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Antiparkinson's: Inbrija and Ongentys

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name:_____2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in days): ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Inbrija - Initial authorization requests **Initial requests can be approved for up 6 months:**

1. Is the member age 18 or older? ☐ Yes ☐ No
2. Does the member have a diagnosis of Parkinson's Disease and is experiencing "off" episodes? ☐ Yes ☐ No
3. Will the member be concurrently receiving optimized carbidopa/levodopa therapy? ☐ Yes ☐ No
4. Is the member currently taking a nonselective monoamine (MAO) inhibitor or has the member taken a MAO inhibitor within the last two weeks? ☐ Yes ☐ No
5. Does the member have asthma, COPD or other chronic lung disease? ☐ Yes ☐ No

Inbrija - Reauthorization requests (please answer questions 1-6) **Reauthorization requests can be approved for up to 12 months:**

6. Has documentation been submitted that indicates the member has had an improvement in their symptoms from baseline? ☐ **Yes** ☐ **No**

Ongentys - initial authorization requests **Initial requests can be approved for up 6 months:**

7. Is the member age 18 years of age or older? ☐ **Yes** ☐ **No**
8. Does the member have a diagnosis of Parkinson's Disease and is experiencing "off" episodes for at least 1.5hours/day on average? ☐ **Yes** ☐ **No**
9. Does the member have no contraindications including ESRD (creatinine clearance <15 ml/min/1.73m2)? ☐ **Yes** ☐ **No**
10. Does the member have no contraindications including severe hepatic impairment (Child-Pugh C)? ☐ **Yes** ☐ **No**
11. Is the member currently taking a nonselective monoamine oxidase-B (MAO-B) inhibitor? ☐ **Yes** ☐ **No**
12. Will the member be concurrently receiving optimized carbidopa/levodopa therapy? ☐ **Yes** ☐ **No**
13. Has the member had an adequate trial and subsequent failure of at least 2 preferred adjunctive therapies (e.g., dopamine agonists, MAO-B inhibitors, catechol-O-methyltransferase [COMT] inhibitors) to control "off" symptoms? ☐ **Yes** ☐ **No**

Ongentys - reauthorization requests (please answer questions 7-15) **Reauthorization requests can be approved for up to 12 months:**

14. Has documentation been submitted that indicates the member has had clinically meaningful response to treatment (e.g., member shows a reduction in time of "off" episodes)? ☐ **Yes** ☐ **No**
15. Has the member experienced toxicity or treatment related adverse event from the drug (e.g., dyskinesias, hallucinations/psychotic behavior, impulse control/compulsive behaviors)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.