



Dopamine Agonists:
Apokyn / Kynmobi (apomorphine) J0364
Prior Authorization Request
Medicare Part B Form

Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.

Form section for NEW START and Continuation information, including fields for Start Date, Date Requested, and Requestor details.

MEMBER INFORMATION

Form section for Member Information, including fields for Name, ID#, and DOB.

PRESCRIBER INFORMATION

Form section for Prescriber Information, including fields for Name, Address, and Phone.

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

Form section for Dispensing Provider / Administration Information, including fields for Name and Address.

PROCEDURE / PRODUCT INFORMATION

Table with 5 columns: HCPC Code, Name of Drug, Dose (Wt: kg Ht:), Frequency, End Date if known.

Form section for Chart notes and other important information.

Form section for Diagnosis: ICD10 and Description.

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

Form section for Clinical Information, including New Start or Initial Request criteria.

Form section for Clinical Information, including Continuation Requests criteria.

ACKNOWLEDGEMENT

Form section for Acknowledgement, including Request By (Signature Required) and Date fields.

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Dopamine Agonist PA

Drug Name(s):

APOKYN
KYNMOBI
A POMORPHINE

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
 - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
 - Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approvals will be for 12 months

FDA Indications:

Apokyn, Kynmobi

- Parkinson's disease, Acute, intermittent treatment of hypomobility "off" episodes

Off-Label Uses:

- Erectile dysfunction
- Induction of emesis, For treatment of acute poisoning
- Parkinsonism; Diagnosis

Age Restrictions:

Safety and effectiveness have not been established in pediatric patients

Other Clinical Considerations:

CI: Concomitant use with serotonin 5-hydroxytryptamine-3 (5-HT₃) receptor antagonists including antiemetics

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/908395/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/DECC9E/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=apomorphine#