



Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization

Dopamine Agonists: apomorphine (APOKYN) inj & apomorphine (KYNMOBI) film

Request Information (required)

This request is:

- Expedited* (Urgent)
- Standard (Non-Urgent)

*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)

Prescriber Information (required)

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

- Medication Requested (Name):
(Go to #2)

Drug Prior Authorization

Dopamine Agonists: apomorphine (APOKYN) inj & apomorphine (KYNMOBI) film

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

Non-Preferred Drug (NPD or NAP)

(Go to #7)

Preferred Drug (PDL)

(Go to #10)

No Status, Drug is not in a Market Basket

(Go to #10)

N/A as this request is for a CHIP/PERINATE member

(Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 14-day treatment trial with at least one (1) preferred agent in the last 180 days?

Yes

(Go to #10)

No

(Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

Yes

(Go to #10)

No

(Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes

(Go to #10)

No (Deny)

(Go to #10)

Clinical Criteria (required)

10. Is the member greater than or equal to (\geq) 18 years of age?

Yes

(Go to #11)

No (Deny)

(Go to #11)

11. Does the member have a diagnosis of Parkinson's disease in the last 730 days?

Yes

(Go to #12)

No (Deny)

(Go to #12)

12. Does the member have a claim for a 5HT₃ antagonist in the last 30 days?

Examples of 5HT₃ antagonists include: alosetron (LOTRONEX), granisetron (SANCUSO), netupitant / palonosetron (AKYNZEO), and ondansetron (ZOFRAN, ZUPLLENZ).

Yes (Deny)

(Go to #13)

No

(Go to #13)

13. Is the request for less than or equal to (\leq) the United States Food and Drug Administration (FDA) recommended dose?

Apomorphine inj (APOKYN) - recommended total daily dose should not exceed 2mL (20 mg) per day & maximum single dose is 0.6mL (6 mg). The member should not receive more than five (5) doses/day.

Apomorphine film (KYNMOBI) - maximum single dose is 30 mg and the member should not receive more than five (5) doses/day.

Yes (Approve - 365 days)

(Go to #14)

No (Deny)

(Go to #14)

Additional Information

14. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Customer Care at 877-908-6023

For questions, please call Navitus Customer Care at 1-877-908-6023.