

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Antiparkinson's Agents-Inbrija and Ongentys



Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 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 to 6 months****:**

- 1. Is the beneficiary age 18 or older? Yes No
- 2. Does the beneficiary have a diagnosis of Parkinson's Disease and is experiencing "off" episodes? Yes No
- 3. Will the beneficiary be concurrently receiving optimized carbidopa/levodopa therapy? Yes No
- 4. Is the beneficiary currently taking a nonselective monoamine (MAO) inhibitor or has the beneficiary taken a MAO inhibitor within the last two weeks? Yes No
- 5. Does the beneficiary 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 beneficiary has had an improvement in their symptoms from baseline? Yes No

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

- 7. Is the beneficiary age 18 years of age or older? Yes No
- 8. Does the beneficiary have a diagnosis of Parkinson's Disease and is experiencing "off" episodes for at least 1.5 hours/day on average? Yes No
- 9. Does the beneficiary have no contraindications including ESRD (creatinine clearance <15 ml/min/1.73m²)?
 Yes No
- 10. Does the beneficiary have no contraindications including severe hepatic impairment (Child-Pugh C)?
 Yes No
- 11. Is the beneficiary currently taking a nonselective monoamine oxidase-B (MAO-B) inhibitor? Yes No
- 12. Will the beneficiary be concurrently receiving optimized carbidopa/levodopa therapy? Yes No
- 13. Has the beneficiary 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 beneficiary has had clinically meaningful response to treatment (e.g., beneficiary shows a reduction in time of "off" episodes)? Yes No
- 15. Has the beneficiary 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.