BlueCross BlueShield Federal Employee Program

APOMORPHINE
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				**Provider Information (required)**			
Date:				Provider Name:			
Patient Name:				Specialty:		NPI:	
Date of Birth:		Sex: ○Male ○Female		Office Phone:		Office Fax:	
Street Address:				Office Street Address:			
City:		State:	Zip:	City:	State:	Zip:	
Patient ID: **R**				Physician Signature:			
PHYSICIAN COMPLETES							

❑**Apokyn (apomorphine) subcutaneous injection** ❑**Onapgo (apomorphine) subcutaneous injection**

NOTE: Form must be completed in its **entirety** for processing

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of Parkinson's disease? ❑Yes* ❑No
   If YES, is the patient experiencing off episodes with Parkinson's disease? ❑Yes ❑No

2. Does the prescriber agree to monitor for QTc prolongation? ❑Yes ❑No

3. Will this medication be used in combination with carbidopa/levodopa? ❑Yes ❑No*
   If NO, does the patient have an intolerance or contraindication to carbidopa/levodopa? ❑Yes ❑No

4. Will this medication be used in combination with a *5HT3 antagonist? ❑Yes ❑No
   If YES, please specify the medication: _____
   5HT3 Antagonists: ondansetron (Zofran, Zuplenz), granisetron (Sustol, Sancuso), dolasetron (Anzemet), palonosetron (Aloxi), alosetron (Lotronex)

5. Has the patient been on this medication continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following question:
   a. Has the patient had inadequate control of Parkinson's off episodes while on maximum tolerated doses of carbidopa/levodopa therapy and adjunctive therapy (e.g., dopamine agonist, COMT inhibitor, etc.)? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient had an improvement in Parkinson's symptoms such as a reduction in daily off time or improvement in motor function post-administration? ❑Yes ❑No