**Central Nervous System (CNS) Agents: Parkinson's Agents**

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| Criteria 1 | NP Criteria  - Carbidopa/Levodopa Dispersible Tab, Carbidopa/Levodopa/Entacapone, Gocovri, Ongentys, Osmolex ER, Pramipexole ER, Rasagiline, Ropinirole ER, Rytary, Tolcapone, Xadago, Zelapar |
| Criteria 2 | NP Criteria with additional info- Apokyn, Inbrija, Kynmobi, Nourianz |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Parkinson's Agents | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| CARBIDOPA/LEVODOPA DISP TAB | 057987 | GCNSeqNo |
| CARBIDOPA/LEVODOPA DISP TAB | 057988 | GCNSeqNo |
| CARBIDOPA/LEVODOPA DISP TAB | 057989 | GCNSeqNo |
| CARBIDOPA/ LEVODOPA/ ENTACAPONE | 052880 | GCNSeqNo |
| CARBIDOPA/ LEVODOPA/ ENTACAPONE | 052881 | GCNSeqNo |
| CARBIDOPA/ LEVODOPA/ ENTACAPONE | 052885 | GCNSeqNo |
| CARBIDOPA/ LEVODOPA/ ENTACAPONE | 063191 | GCNSeqNo |
| CARBIDOPA/ LEVODOPA/ ENTACAPONE | 064514 | GCNSeqNo |
| CARBIDOPA/ LEVODOPA/ ENTACAPONE | 064515 | GCNSeqNo |
| GOCOVRI | 077685 | GCNSeqNo |
| GOCOVRI | 077686 | GCNSeqNo |
| ONGENTYS | 079348 | GCNSeqNo |
| ONGENTYS | 080978 | GCNSeqNo |
| OSMOLEX ER | 078185 | GCNSeqNo |
| OSMOLEX ER | 078186 | GCNSeqNo |
| OSMOLEX ER | 081019 | GCNSeqNo |
| PRAMIPEXOLE ER | 065761 | GCNSeqNo |
| PRAMIPEXOLE ER | 065762 | GCNSeqNo |
| PRAMIPEXOLE ER | 065763 | GCNSeqNo |
| PRAMIPEXOLE ER | 065764 | GCNSeqNo |
| PRAMIPEXOLE ER | 065765 | GCNSeqNo |
| PRAMIPEXOLE ER | 067522 | GCNSeqNo |
| PRAMIPEXOLE ER | 067523 | GCNSeqNo |
| RASAGILINE | 059121 | GCNSeqNo |
| RASAGILINE | 060915 | GCNSeqNo |
| ROPINIROLE ER | 063858 | GCNSeqNo |
| ROPINIROLE ER | 063859 | GCNSeqNo |
| ROPINIROLE ER | 063860 | GCNSeqNo |
| ROPINIROLE ER | 064594 | GCNSeqNo |
| ROPINIROLE ER | 065109 | GCNSeqNo |
| RYTARY | 073308 | GCNSeqNo |
| RYTARY | 073309 | GCNSeqNo |
| RYTARY | 073310 | GCNSeqNo |
| RYTARY | 073311 | GCNSeqNo |
| TOLCAPONE | 035580 | GCNSeqNo |
| XADAGO | 075078 | GCNSeqNo |
| XADAGO | 075079 | GCNSeqNo |
| ZELAPAR | 054736 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | END (Pending Manual Review) |
| 6 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Central Nervous System (CNS) Agents: Parkinson's Agents | | |
| **Criteria Subtitle** | Apokyn, Inbrija, Kynmobi, Nourianz | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| APOKYN | 044660 | GCNSeqNo |
| INBRIJA | 079392 | GCNSeqNo |
| KYNMOBI | 081092 | GCNSeqNo |
| KYNMOBI | 081096 | GCNSeqNo |
| KYNMOBI | 081097 | GCNSeqNo |
| KYNMOBI | 081098 | GCNSeqNo |
| KYNMOBI | 081099 | GCNSeqNo |
| NOURIANZ | 080177 | GCNSeqNo |
| NOURIANZ | 080178 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response to at least 30 days with one other drug for the treatment of “off episodes” (dopamine agonist, COMT inhibitor, or MAO-B inhibitor)?  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1235 |
| 6 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | END (Pending Manual Review) |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 10 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |