Prior Authorization Request Form for
levodopa inhalation powder (**Inbrija**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Does the patient have a diagnosis of Parkinson's disease?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Is the patient currently taking and will continue taking carbidopa-levodopa therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient continued to experience wearing off periods, despite optimizing carbidopa/levodopa therapy (for example, increasing the dose or increasing the frequency of dosing)?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Will Inbrija be used concomitantly with, or within 2 weeks of, a non-selective monoamine oxidase (MAO) inhibitor (for example, phenelzine, tranylcypromine, isocarboxazid, hydracarbazine)?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **7**
7. Does the patient have a chronic underlying pulmonary disease (for example, asthma, COPD)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[14 August 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: