Prior Authorization Request Form for
rotigotine **(Neupro)** patch

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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. **For which diagnosis is the requested medication being prescribed?**	☐ **Parkinson's disease** - Proceed to question **3** ☐ **Moderate to severe primary restless legs syndrome** - Proceed to question **3** ☐ **Other – STOP Coverage not approved**	
3. **Is the patient unable to swallow tablets due to a documented medical condition (for example dysphagia, oral candidiasis, systemic sclerosis, etc.) and not due to convenience?**	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. **Has the patient tried and failed or has a contraindication to other dopamine agonist oral therapy: pramipexole (Mirapex) OR ropinorole (Requip)?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

_____ _____
Prescriber Signature Date

[13 May 2020]

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