7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

Prior Authorization Request Form for
istradefylline **(Nourianz)**

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:

Question	Yes	No
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 [1] ?	☐ 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. Does the patient continue to experience wearing off periods, despite optimizing (for example, increasing dose and daily frequency) carbidopa/levodopa therapy?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient tried and failed an adequate trial of at least two drugs from any of the three classes: • **Dopamine Agonist (pramipexole, ropinirole, rotigotine)** • **MAO-B (rasagiline, selegiline)** • **COMT (tolcapone, entacapone)**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

[1] Coverage is not approved for use in non-FDA approved conditions, to include restless legs syndrome.

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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

[19 February 2020]

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