

State of Idaho, Division of Medicaid

ANTI-PARKINSON AGENTS

PRIOR AUTHORIZATION FORM

CONFIDENTIAL INFORMATION

Phone: 1-208-364-1829

One drug per form ONLY – Use black or blue ink

Fax: 1-208-364-1864

Patient Name: _____	Medicaid ID#: _____	D.O.B.: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store#: _____	Phone: _____	Fax: _____

Preferred agents will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.

Non-preferred agents will be approved for payment only after documented failure of 1 preferred agent.

Generic products required when available. Use of a brand name product with a generic equivalent requires additional documentation.

Medication Requested:

Preferred Agents:

Benzotropine	NO PA REQUIRED	Carbidopa/levodopa	NO PA REQUIRED
Trihexyphenidyl	NO PA REQUIRED	Selegiline	NO PA REQUIRED
Kemadrin®	NO PA REQUIRED	Mirapex®	NO PA REQUIRED
Requip®	NO PA REQUIRED	Stalevo™	NO PA REQUIRED

Non-Preferred Agents:

<u>Drug</u>	<u>Strength</u>	<u>Dosing Instructions</u>
<input type="checkbox"/> Parcopa®	_____	_____
<input type="checkbox"/> Pergolide	_____	_____
<input type="checkbox"/> Tasmar®	_____	_____

History of preferred agent(s):

<u>Drug</u>	<u>Dates of Trial</u>	<u>Reason(s) for Failure</u>
_____	_____	_____
_____	_____	_____

Other pertinent information for review:

Prescriber Signature: _____ Date: _____

By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.

For Medicaid Office Use Only			
Date:	RPh:	Tech:	PA#:
Approved	Denied	Comments:	