# US Family Health Plan
# Prior Authorization Request Form for
# istradefylline **(Nourianz**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

**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<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Does the patient have a diagnosis of Parkinson's disease [1] ?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Is the requested medication being prescribed by or in consultation with a neurologist?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Is the patient currently taking and will continue taking carbidopa-levodopa therapy?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**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<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Has the patient tried and failed an adequate trial of at least two drugs from any of the three classes:**<br>**•Dopamine Agonist (pramipexole, ropinirole, rotigotine)**<br>**• MAO-B (rasagiline, selegiline)**<br>**• COMT (tolcapone, entacapone)** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

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

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

Prescriber Signature _____ Date _____

[19 February 2020]