US Family Health Plan
Prior Authorization Request Form for
safinamide (**Xadago**)

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:

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?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and failed rasagiline or selegiline?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Will Xadago be used as an adjunct to levodopa/carbidopa or a dopamine agonist?	☐ 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

[01 November 2017]