US Family Health Plan
Prior Authorization Request Form for

levodopa inhalation powder (**Inbrija**)

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 855-273-5735

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**

Supporting clinical documentation is required.

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. Does the patient have a diagnosis of Parkinson's disease?	☐ 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. Has the patient continued to experience wearing off periods, despite optimizing carbidopa/levodopa therapy (for example, increasing the dose or increasing the frequency of dosing)?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Will Inbrija be used concomitantly with, or within 2 weeks of, a non-selective monoamine oxidase (MAO) inhibitor (for example, phenelzine, tranylcypromine, isocarboxazid, hydracarbazine)?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **7**
7. Does the patient have a chronic underlying pulmonary disease (for example, asthma, COPD)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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

Prescriber Signature _____ Date _____

[14 August 2019]