PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xadago (safinamide)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the prescriber a Neurologist?

☐ Yes ☐ No

Q2. Is the patient ≥18 years of age?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of Parkinson's disease (PD)?

☐ Yes ☐ No

Q4. Please provide ICD code(s) for diagnosis.

Q5. Will the patient be using levodopa/carbidopa concomitantly?

☐ Yes ☐ No

Q6. Does the patient have "off" time greater than 1.5 hours per day, excluding morning akinesia? "Off" time is defined as time when medication effect has worn off and parkinsonian features, including bradykinesia and rigidity, return.

☐ Yes ☐ No

Q7. Will the member have concomitant use of ANY of the following? Please select all that apply.

☐ Other monoamine oxidase inhibitors or other drugs that are potent inhibitors of monoamine oxidase (e.g.

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linezolid)

- ☐ Opioid drugs (e.g. tramadol, meperidine and related derivatives)
- ☐ Selective norepinephrine reuptake inhibitors (SNRI)
- ☐ Tri- or tetra-cyclic or triazolopyridine antidepressants
- ☐ Cyclobenzaprine
- ☐ Methylphenidate, amphetamine, and their derivatives
- ☐ St. John's wort
- ☐ Dextromethorphan
- ☐ None of the above

Q8. Does the patient have severe hepatic impairment (Child-Pugh C:10-15)?

☐ Yes ☐ No

Q9. Please select all of the following that the patient has failure of or contraindication to.

- ☐ Entacapone
- ☐ Pramipexole
- ☐ Rasagiline
- ☐ Ropinirole
- ☐ Tocapone
- ☐ Selegiline
- ☐ Other (please specify)

Q10. Additional Comments

Prescriber Signature

Date

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□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.