

**Physician's Prior Authorization Questionnaire
Apokyn® (apomorphine)**

Patient:

ID#:

DOB:

Patient Address:

Apokyn® (apomorphine) is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. Does the patient have a diagnosis of moderate or advanced Parkinson's disease? Yes No
2. Does the patient have troublesome motor fluctuations despite optimization of oral drug therapy for Parkinson's disease? Yes No
3. Is the patient using Apokyn® (apomorphine) in combination with other medications to treat Parkinson's disease? Yes No
4. Is the patient using Apokyn® (apomorphine) in combination with antiemetic therapy during initiation (trimethobenzamide)? Yes No

Apokyn® (apomorphine) will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number / Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx