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## VYALEV PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
<b>RECEIPIENT INFORMATION</b>		
Medicaid ID:	Date of Birth:	Sex:    M        F
Last Name:		First Name:
<b>GENERAL INFORMATION</b>		
First Date of Service:		Last Date of Service:
Primary Diagnosis Code:		HCPC Code:
Drug Name:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
<b>POINT OF CONTACT</b>		
Name and Title:		
Email:	Phone:	Fax:
<small><i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i></small>		
<b>REFERRING PROVIDER INFORMATION</b>		
Name:		
NPI #:		Taxonomy:
Phone:		Fax:
<b>SERVICING PROVIDER INFORMATION</b>		
Name:		
Address:		
NPI #:		Taxonomy:
Phone:		Fax:

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Therapy must be prescribed by or in consultation with a neurologist	
	Individual has a diagnosis of idiopathic Parkinson's disease	
	Documentation is provided indicating that the individual is levodopa responsive	
	Individual has an average "off time" of at least 3 hours per day and <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Individual is currently taking optimized treatment with oral carbidopa/levodopa dosed at least 4 times daily</li> <li>• Individual has documented intolerance or inability to take oral carbidopa/levodopa</li> </ul>	
	Individual is $\geq$ 18 years of age	
<b>Continuation of Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Documentation is provided indicating off time has reduced since starting therapy	
	If patient met initial approval for therapy due to inability to take oral carbidopa/levodopa, this inability is still present	
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
This form <u>must be</u> signed by a provider		
	I certify that the information given in this form is a true and accurate medical indication for the required product	
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		