Prescriber Criteria Form Inbrija 2024 PA Fax 2861-A v1 010124.docx Inbrija (levodopa inhalation powder) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Inbrija (levodopa inhalation powder).

Drug Name: Inbrija (levodopa inhalation powder)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of Parkinson's disease? [If no, then no further questions.]	Yes	No
2	Does the patient experience "off" episodes? [If no, then no further questions.]	Yes	No
3	Is this a request for continuation of therapy? [If no, then skip to question 5.]	Yes	No
4	Has the patient experienced improvement on the requested drug? [No further questions.]	Yes	No
5	Is the patient currently being treated with oral carbidopa/levodopa? [If no, then no further questions.]	Yes	No
6	Does the patient have any of the following: A) asthma, B) chronic obstructive pulmonary disease (COPD), C) other chronic underlying lung disease?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____