



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE- APOKYN®

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

- | | | |
|---|-----|----|
| 1. Does the patient have Parkinson's disease? | Yes | No |
| 2. Has the patient progressed to Stage 4 Parkinson's disease? | Yes | No |
| 3. Is the patient currently being treated with levodopa? | Yes | No |
| 4. Does the patient experience "off" episodes that lead to immobility or impairment in ability to perform activities of daily living? | Yes | No |
| 5. Will the patient be treated prophylactically with an antiemetic other than a 5HT ₃ receptor antagonist? | Yes | No |
| 6. IF THIS IS A RENEWAL: Has the patient demonstrated a reduced frequency of "off" episodes and improved health-related quality of life? | Yes | No |
| 7. Is the patient being treated with a serotonin receptor antagonist [i.e. ondansetron (Zofran), granisetron (Kytril), Dolasetron (Anzemet), palonosetron (Aloxi) or alosetron (Lotronex)]? | Yes | No |

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095
www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906

Initial approval will be for a 12-month period. If patient has demonstrates responses to therapy within this time frame, additional 12-month approvals will be authorized.