



Prior Authorization Request Form – Zelapar (selegiline orally disintegrating tablets)

Instructions:

This form is to be used by participating providers to request coverage for Zelapar (selegiline orally disintegrating tablets). Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
Fax: 1-800-918-7542

A Zelapar (selegiline orally disintegrating tablets) step therapy program has been developed to encourage the use of first-line therapies before Zelapar for the same indication. If approved, quantity limits of 60 tablets per 30 days apply.
First-line therapies: selegiline tablets, levodopa/carbidopa tablets
Second-line therapy: Zelapar orally disintegrating tablets

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
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4. Prescriber's FULL Name & Specialty: Mailing Address:	5. Contact Person at Office:
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Prescriber's FAX & Telephone Number: Fax: () Tel: ()

7. Requested Drug:	8. Dose, Frequency, and Duration of the therapy:
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9. Has the member been started and stabilized on the requested drug? Yes No
- If 'yes', please provide duration of the therapy = _____

10. Has the member previously tried generic selegiline? Yes No
- If 'yes', what was the outcome of the trial? side-effect inadequate response Other: _____

11. Is the member currently taking levodopa/carbidopa? Yes No

12. Prescriber comments:

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature

Date