



UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2023 P 1344-4
Program	Prior Authorization/Notification
Medication	Apokyn® (apomorphine) injection
P&T Approval Date	12/2020, 12/2021, 12/2022, 12/2023
Effective Date	3/1/2024

**1. Background:**

Apokyn is a non-ergoline dopamine agonist indicated for the acute, intermittent treatment of hypomobility, “off” episodes (“end-of-dose wearing off” and unpredictable “on/off” episodes) associated with advanced Parkinson’s disease.

Coverage will be provided for members who meet the following criteria.

**2. Coverage Criteria<sup>a</sup>:**

**A. Initial Authorization**

1. **Apokyn** will be approved based on **both** of the following:

a. Diagnosis of Parkinson’s disease

**-AND-**

b. Used as intermittent treatment for OFF episodes

**Authorization will be issued for 6 months.**

**B. Reauthorization**

1. **Apokyn** will be approved based on the following criteria:

a. Documentation of positive clinical response to **Apokyn** therapy

**Authorization will be issued for 12 months.**

<sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and/or Medical Necessity may be in place.



**4. References:**

1. Apokyn [package insert]. Rockville, MD: MDD US Operations, LLC; June 2022.

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<b>Change Control</b>	
12/2020	New program
12/2021	Annual review with no changes.
12/2022	Annual review with no changes to clinical coverage criteria. Added state mandate footnote and updated reference.
12/2023	Annual review with no changes to coverage criteria.