OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: Gocovri™ (amantadine) **Extended Release (Medicaid)**

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: ____

Dosing Schedule: ______________________ **Length of Therapy**: ______________

Diagnosis: _________________________ **ICD Code, if applicable**: ____________

Quantity Limit: 68.5mg = 34 capsules/34 days; 137 mg = 68 capsules/34 days

CLINICAL CRITERIA: To receive a **ONE (1) year approval** for this drug, **ALL** boxes **MUST** be checked to qualify or authorization process may be delayed. Chart notes **MUST** be submitted with this request.

1. Does member have dyskinesia associated with Parkinson's disease? ❑ Yes ❑ No
2. Is member 18 ≥ years of age? ❑ Yes ❑ No
3. Is member on concomitant levodopa-based therapy? ❑ Yes ❑ No
4. Has member had an adequate trail of or is intolerant to amantadine immediate-release? ❑ Yes ❑ No
5. Member does **NOT** have end-stage renal disease (creatinine clearance < 15 mL/min/1.73 m^2)? ❑ Yes ❑ No
6. Member will **NOT** receive live vaccines during treatment (inactivated vaccines may be utilized)? ❑ Yes ❑ No

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ____

Member Optima #: ___________________________ Date of Birth: ______________

Prescriber Name: ____

Prescriber Signature: ________________________________ Date: ____________

Office Contact Name: ____

Phone Number: ______________________________ Fax Number: ________________

DEA OR NPI #: ____

***Approved by Pharmacy and Therapeutics Committee**: 2/15/2018
REVISED/UPDATED: ~~6/21/2018;~~ **8/20/2018**