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: select the applicable drug below

❑ **Gocovri™ Extended Release** (amantadine extended release)	❑ **Osmolex ER™** (amantadine extended release)

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**: _____

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

For Osmolex ER™
Quantity Limit: 129mg = 34 capsules/34 days; 193mg = 34 capsules/34 days; 258mg = 34 capsules/34 days
Maximum daily dose of 322mg (administered as a 129mg and 193mg tablet).

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. For **Gocovri™ ER** - Does the member have dyskinesia associated with Parkinson's disease? ❑ Yes ❑ No

   For **Osmolex ER™** - Does the member have a diagnosis of Parkinson's disease or drug-induced extra pyramidal reactions? ❑ Yes ❑ No

   AND

2. For Gocovri™ ER – Is the member on concomitant levodopa-based therapy? ❑ Yes ❑ No

   AND

3. Is member 18 ≥ years of age? ❑ Yes ❑ No

   AND

4. Has member had an adequate trail of or is intolerant to amantadine immediate-release? ❑ Yes ❑ No

   AND

(Continued on next page.)

5. Member does **NOT** have end-stage renal disease (creatinine clearance < 15 mL/min/1.73 m^2)?
   ❑ Yes ❑ No

AND

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;~~ **11/3/2018**;