OPTIMA HEALTH PLAN

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**

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***: __________________

*****Maximum Allowed Daily Qty: 1 capsule/day for the 68.5mg and 2 capsules/day for the 137mg***

CLINICAL CRITERIA: ALL boxes below MUST be checked to qualify or authorization process may be delayed. Chart notes MUST be submitted with this request.

- ❑ Medication must be prescribed a neurologist or psychiatrist;

  AND

- ❑ Individual is 18 years of age or older;

  AND

- ❑ Member has a confirmed diagnosis of dyskinesia with Parkinson's disease and is receiving levodopa-based therapy, with or without concomitant dopaminergic medications ;

  AND

- ❑ Patient has tried and failed ***at least 30 days*** of therapy with generic immediate-release amantadine ***(chart notes must be submitted to verify therapy failure)***;

  AND

- ❑ Member has **NO** contraindications to therapy, including end stage renal disease ***(defined as creatinine clearance 15 mL/min/1.73 m2***)

*****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