SENTARA COMMUNITY PLAN
(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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Gocovri™ ER (amantadine extended release)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy

- **Gocovri ER™**
  - **Quantity Limit:** 68.5mg = 34 capsules/34 days; 137 mg = 68 capsules/34 days

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization length – 1 year

1. Does the member have dyskinesia associated with Parkinson's disease?
   ❑ Yes ❑ No
2. Is the member receiving levodopa-based therapy, with or without concomitant dopaminergic medications? ❑ Yes ❑ No
3. Is the member using this as adjunctive treatment to levodopa/carbidopa in member's with Parkinson's disease experiencing "off" episodes? ❑ Yes ❑ No
4. Is the member 18 years of age or older? ❑ Yes ❑ No
5. Has the member had an adequate trail of or is intolerant to amantadine immediate-release?
   ❑ Yes ❑ No
6. Does the member have end-stage renal disease (creatinine clearance < 15 mL/min/1.73 m^2)?
   ❑ Yes ❑ No
7. Will the member 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.*

***Approved by Pharmacy and Therapeutics Committee**: 2/15/2018
REVISED/UPDATED/REFORMATTED: ~~6/21/2018; 8/20/2018; 11/3/2018; 1/29/2020; 11/7/2023;~~ **10/16/2026**