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: (select the applicable drug below)

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

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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: 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

(Continued on next page.)

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

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.

***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**