AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Gocovri and Osmolex ER

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Gocovri – Initial authorization requests: **Initial requests can be approved for up to 6 months.**

1. Is the beneficiary age 18 or older? Yes___ No___
2. Does the beneficiary have a diagnosis of dyskinesia due to Parkinson's disease AND is receiving levodopa-based therapy, with or without dopaminergic medications? Yes___ No___
3. Does the beneficiary have no contraindications including ESRD (creatinine clearance <15 ml/min/1.73m^2)? Yes___ No___
4. Does the beneficiary have a trial and failure of, or intolerance to, immediate-release amantadine (capsule, tablet, or oral solution)? Yes___ No___
5. Does the beneficiary have a diagnosis of Parkinson's Disease and is experiencing "off" episodes? Yes___ No___
6. Will the beneficiary be concurrently receiving optimized carbidopa/levodopa? Yes___ No___

Gocovri – Reauthorization requests (answer questions 1-7): **Reauthorization requests can be approved for up to 12 months**

7. Has documentation been submitted that indicates the beneficiary has had an improvement in their symptoms from baseline? Yes___ No___

Osmolex ER – Initial authorization requests: **Initial requests can be approved for up 6 months**

8. Is the beneficiary age 18 or older? Yes___ No___
9. Does the beneficiary have a diagnosis of Parkinson's disease or Drug-induced extrapyramidal reactions? Yes___ No___
10. Does the beneficiary have no contraindications including ESRD (creatinine clearance <15 ml/min/1.73m^2)? Yes___ No___
11. Does the beneficiary have a trial and failure of immediate-release amantadine (capsule, tablet, or oral solution)? Yes___ No___

Osmolex ER - Reauthorization requests (answer questions 8-12): **Reauthorization requests can be approved for up to 12 months**

12. Has documentation been submitted that indicates the beneficiary has had an improvement in their symptoms from baseline? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406