carolina complete health

Pharmacy Prior Approval Request for Gocovri

Beneficiary Information

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

Prescriber Information

7. Prescribing Provider NPI #: ____
8. Requester Contact Information
   Name:________________________________ Phone #:____________________________ Ext. _____________

Drug Information

9. Drug Name: ________ 10. Strength:________________ 11. Quantity Per 30 Days: ______________________
12. Length of Therapy (days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: __________

Clinical Information

Initial Requests

1. Does the beneficiary have a diagnosis of dyskinesia due to Parkinson's disease? ☐ Yes ☐ No
2. Is the beneficiary receiving levodopa-based therapy with or without dopaminergic medications? ☐ Yes ☐ No
3. Does the beneficiary have any contraindications including ESRD (creatinine clearance < 15ml/min) ☐ Yes ☐ No
4. Does the beneficiary have failure, contraindication, or intolerance to immediate-release amantadine (capsule, tablet, or oral solution)? ☐ Yes ☐ No
   Please list:____

Continuation Requests answer 1-4 above and 5 below:

5. Has documentation been attached to this request 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: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309