



Pharmacy Prior Approval Request for Antiparkinson’s Agents- 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. Prescribing Provider NPI #: _____
 7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
 11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

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/1.73m2)?
 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 (please answer questions 1-5) **Reauthorization requests can be approved for up to 12 months****:**

5. 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 to 6 months****:**

6. Is the beneficiary age 18 years of age or older? Yes No
7. Does the beneficiary have a diagnosis of Parkinson's disease or Drug-induced extrapyramidal reactions?
 Yes No
8. Does the beneficiary have no contraindications including ESRD (creatinine clearance <15 ml/min/1.73m2)?
 Yes No
9. Does the beneficiary have a trial and failure of immediate-release amantadine (capsule, tablet, or oral solution)?
 Yes No

Osmolex ER - reauthorization requests (please answer questions 6-10) **Reauthorization requests can be approved for up to 12 months****:**

10. 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: (833) 404-2393

Pharmacy PA Call Center: (833) 585-4309

<https://www.covermyeds.com/main/prior-authorization-forms/>