UnitedHealthcare Community Plan

NC 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 #: _____ Provider Fax #: _____
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 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 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.