WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for 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 six (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 immediate-release amantadine (capsule, tablet, or oral solution)? ☐ **Yes** ☐ **No**

Gocovri – reauthorization requests (please answer questions 1-5) ****Reauthorization requests can be approved for up to twelve (12) months**:**
5. Has documentation been submitted that indicates the beneficiary's symptoms have improved from baseline? ☐ **Yes** ☐ **No**

Osmolex ER – initial authorization requests ****Initial requests can be approved for up six (6) months**:**
6. Is the beneficiary age 18 years 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 twelve (12) months:**
10. Has documentation been submitted that indicates the beneficiary's symptoms have improved 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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**