US Family Health Plan
Prior Authorization Request Form for
amantadine ER **(Gocovri)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of Parkinson's Disease?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient using the requested medication for the treatment of dyskinesia and receiving levodopa-based therapy, with or without concomitant dopaminergic medications?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
4. Has the patient experienced therapeutic failure with a trial of amantadine immediate release of at least 300 mg daily in divided doses?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Is the patient using the requested medication for the treatment of "off" episodes and receiving levodopa/carbidopa?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[01 September 2021]