Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Antiparkinson's: Gocovri and Osmolex ER

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Gocovri** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. 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 member age 18 or older? ☐ **Yes** ☐ **No**
2. Does the member 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 member have no contraindications including ESRD (creatinine clearance <15 ml/min/1.73m2)? ☐ **Yes** ☐ **No**
4. Does the member 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 12 months**:**

5. Has documentation been submitted that indicates the member 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 member age 18 years of age or older? ☐ **Yes** ☐ **No**
7. Does the member have a diagnosis of Parkinson's disease or Drug-induced extrapyramidal reactions? ☐ **Yes** ☐ **No**
8. Does the member have no contraindications including ESRD (creatinine clearance <15ml/min/1.73m2)? ☐ **Yes** ☐ **No**
9. Does the member 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 member 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277