TEXAS MEDICAID
Clinical Edit Prior Authorization
Amantadine ER Agents

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 14-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of Parkinson's disease in the last 730 days?

   ☐ Yes (Go to #4)
   ☐ No (Request is for Osmolex ER, go to #3)
   ☐ No (Request is for Gocovri, deny)

3. Does the client have a diagnosis of drug-induced extrapyramidal reaction in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Has the client had at least 60 days therapy of the requested agent in the last 90 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #5)

5. Has the client had a trial (at least 30 days therapy in the last 60 days) of immediate-release amantadine?

   ☐ Yes (Go to #6) ☐ No (Deny)

6. Is the client currently taking a levodopa-containing medication (at least 60 days supply in the last 90 days)?

   ☐ Yes (Go to #7)
   ☐ No (Request is for Osmolex ER, go to #7)
   ☐ No (Request is for Gocovri, deny)

7. Does the client have a diagnosis of end stage renal disease (ESRD) in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #8)

8. Is the requested dose less than or equal to (≤) 1 capsule daily?

   ☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.