CRITERIA FOR DRUG COVERAGE
amantadine ER (Gocovri™)

**Initial approval criteria:** Non-formulary amantadine ER (Gocovri™) will be covered for **12 months** on the prescription drug benefit when the following criteria are met:

- Prescribed by a neurologist with expertise in diagnosis/treatment of Parkinson’s Disease
- **AND**
- Diagnosis of Parkinson’s Disease on problem list
- **AND**
- Patient currently prescribed carbidopa/levodopa 3 times per day or more
- **AND**
- Patient has dyskinetic movements that have responded to adequate trial (at least 4 weeks) of amantadine immediate-release capsule
- **AND**
- Patient has documented inability to utilize amantadine immediate-release capsule due to frequency of dosing
- **OR**
- Dose Change Only: Patient previously met criteria and is already taking the drug
- **OR**
- **New Member:** Patient to be transitioned to amantadine immediate-release capsule if above criteria not met

**Continued use criteria:** Non-formulary amantadine ER (Gocovri™) will continue to be covered for **12 months** on the prescription drug benefit when the following criteria are met:

- Continued to be prescribed by a neurologist with expertise in diagnosis/treatment of Parkinson’s Disease
- **AND**
- Patient has had a visit with a neurologist within the last 12 months
- **AND**
- Total daily dose does not exceed 274 mg