Pharmacy Medical Necessity Guidelines:
Gocovri® (amantadine extended-release)

Effective: March 10, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Gocovri® (amantadine extended-release) is indicated for the treatment of dyskinesia in patients with Parkinson's disease receiving levodopa-based therapy, with or without dopaminergic drugs. Gocovri is also indicated as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease experiencing "off" episodes. Gocovri is available as 68.5mg and 137mg capsules.

COVERAGE GUIDELINES

The plan may authorize coverage of **Gocovri® (amantadine extended-release)** for Members, when **ALL** of the following criteria are met:

1. Member has a diagnosis of Parkinson's disease with either dyskinesias or "off" episodes

AND

2. Member has been receiving levodopa-based therapy

AND

3. Member has as an inadequate response or intolerance to amantadine immediate-release or documentation that treatment with the extended-release formulation of amantadine is medically necessary

LIMITATIONS

None

CODES

None

REFERENCES

1. Gocovri (amantadine extended-release) [prescribing information]. Emeryville, CA: Adamas Pharma, LLC; January 2021.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. June 13, 2023: No changes.
2. March 12, 2024: Effective April 1, 2024, updated criteria to include documentation that treatment with the extended-release formulation of amantadine is medically necessary. Updated RxUM fax number.
3. March 11, 2025: No changes
4. March 10, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical

Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services