This letter is only intended as a SAMPLE Letter of Medical Necessity
For GOCOVRI® (amantadine) extended release capsules
PLEASE USE PROVIDER'S LETTERHEAD

Date:

Insurance Company Name
Street Address
City, State, Zip Code

Re: Letter of Medical Necessity for: Patient Name, Date of Birth, Policy ID#, Group#

To whom it may concern:

I am writing this letter on behalf of my patient, <patient's name>, to formally document medical necessity for treatment with GOCOVRI (amantadine) extended release capsules which is indicated for the treatment of dyskinesia (sudden uncontrolled movements) in Parkinson's disease patients treated with levodopa-based therapy, with or without concomitant dopaminergic medicines and as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease experiencing "off" episodes.

I have considered the clinical efficacy and safety data regarding the impact of GOCOVRI for ON time without troublesome dyskinesia and OFF episodes as detailed in the Prescribing Information. Due to its unique formulation, GOCOVRI is not interchangeable with other amantadine immediate or extended-release products as referenced in the prescribing information section 2.1.

My judgement is that this is the appropriate therapy for this patient because it is the only FDA-approved medication for the treatment of both OFF episodes and dyskinesia, with a clinical profile that addresses the issues highlighted in the medical and treatment history as detailed below.

Medical History

Patient's medical history, diagnosis and current conditions

Treatment History

Prior treatments and response to those treatments

Based on my clinical assessment, GOCOVRI is medically necessary to treat <patient's name>'s Parkinson's disease motor complications, OFF episodes and dyskinesia.

If you have any concerns about approving this necessary treatment for my patient, please contact my office at <office phone number> and I will be happy to discuss further.

Sincerely,

<Provider's name>