pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ALZHEIMER'S AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Alzheimer's Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # of pages: _______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred medication requested ***(clinical prior authorization required)*:**
- ☐donepezil 5mg or 10 mg tablet
- ☐Exelon transdermal patch
- ☐memantine tablet
- ☐memantine titration pack

Non-preferred medication requested:
- ☐Aricept tablet
- ☐donepezil 23 mg tablet
- ☐donepezil ODT
- ☐galantamine solution
- ☐galantamine tablet
- ☐galantamine ER capsule
- ☐memantine solution
- ☐memantine ER capsule
- ☐Namenda tablet
- ☐Namenda titration pack
- ☐Namenda XR capsule
- ☐Namenda XR titration pack
- ☐Namzaric capsule
- ☐Namzaric titration pack
- ☐Razadyne tablet
- ☐Razadyne ER capsule
- ☐rivastigmine capsule
- ☐rivastigmine patch
- ☐____________________

Strength:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (required):	

INITIAL requests

Question	Response
1. Is the beneficiary's diagnosis listed in either the medication's package insert OR nationally recognized compendia for the determination of medically accepted indications for off-label uses?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*
2. ***Requests for NON-PREFERRED agents only:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Alzheimer's Agents? *Check all that apply.* ☐donepezil 5 mg or 10 mg tablet ☐Exelon transdermal patch ☐memantine tablet	☐Yes ☐No *Submit documentation of medication regimens tried and treatment results, contraindications, and/or intolerances.*

RENEWAL requests

Question	Response
1. Does the beneficiary have a documented rationale for continuing the requested medication?	☐Yes – *Submit medical record documentation.* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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