

ALZHEIMER'S AGENTS PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Alzheimer's Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Alzheimer's Agents** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>). Refer to the list of **Quantity Limits/Daily Dose Limits** at <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:			
Preferred Agents	Non-Preferred Agents		
<input type="checkbox"/> donepezil 5mg & 10 mg tablet <input type="checkbox"/> Exelon transdermal patch <input type="checkbox"/> memantine tablet	<input type="checkbox"/> Aricept tablet <input type="checkbox"/> Aricept ODT <input type="checkbox"/> donepezil 23 mg tablet <input type="checkbox"/> donepezil ODT <input type="checkbox"/> Exelon capsule <input type="checkbox"/> galantamine tablet	<input type="checkbox"/> galantamine ER capsule <input type="checkbox"/> galantamine solution <input type="checkbox"/> memantine solution <input type="checkbox"/> Namenda XR capsule <input type="checkbox"/> Namenda solution	<input type="checkbox"/> Namzaric capsule <input type="checkbox"/> Razadyne tablet <input type="checkbox"/> Razadyne ER capsule <input type="checkbox"/> rivastigmine capsule <input type="checkbox"/> rivastigmine patch
Strength:	Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		DX code (required):	
Section A: All initial requests			
1. Is the Recipient'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?		<input type="checkbox"/> Yes <input type="checkbox"/> No – <i>submit documentation of peer-reviewed medical literature supporting the use of the requested medication for the Recipient's diagnosis</i>	
Section B: Initial non-preferred requests			
1. Has the Recipient tried and failed any of the preferred Alzheimer's Agents? <input type="checkbox"/> donepezil 5 mg or 10 mg tablet <input type="checkbox"/> Exelon transdermal patch <input type="checkbox"/> memantine tablet		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication regimens tried and failed</i> <input type="checkbox"/> No	
2. Does the Recipient have a contraindication or intolerance to any of the preferred Alzheimer's Agents listed in question (1)?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication name(s) and associated intolerances/contraindications</i> <input type="checkbox"/> No	
Section C: All renewal requests			
1. Does the Recipient have a documented rationale for continuing the requested medication?		<input type="checkbox"/> Yes – <i>submit medical record documentation</i> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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