



Prior Authorization Request Form for Alzheimer's Agents

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at <https://www.covermy meds.com/main/prior-authorization-forms/>

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)

Specify diagnosis & diagnosis code relevant to this request: _____ Dx/Dx Code: _____

<p>Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Alzheimer's Agents? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.</p>	<p><input type="checkbox"/> Yes Medications Taken (start and end date and dose): _____</p> <p><input type="checkbox"/> No _____</p>
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If requesting for daily quantity exceeding daily limit (Refer to <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx>), please provide supporting information: _____

Therapeutic Duplication:
If concurrently prescribed a therapeutic duplicate (i.e. another Acetylcholinesterase Inhibitor or dose different from the agent being requested):

is being transitioned from one Acetylcholinesterase Inhibitor to another with the intent of discontinuing one of the medications

has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines. Supporting evidence: _____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature: _____	Date: _____
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Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)