

## Prior Authorization Request Form for Alzheimer's Agents

**FAX this completed form to (877) 386-4695**

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

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:		Member Name:	
Prescriber Specialty:		Identification #:	
Office Contact Name:		Group #:	
Group 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: _____	
<b>Requests for all non-preferred medications:</b> Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Alzheimer's Agents? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes <i>Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.</i> <input type="checkbox"/> No	
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to <a href="https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx">https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx</a> ), please provide supporting information: _____			
<b>Therapeutic Duplication:</b> If concurrently prescribed a therapeutic duplicate (i.e. another Acetylcholinesterase Inhibitor or dose different from the agent being requested): <input type="checkbox"/> is being transitioned from one Acetylcholinesterase Inhibitor to another with the intent of discontinuing one of the medications <input type="checkbox"/> has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines			
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:

Envolve Pharmacy Solutions 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.)