Premier Health Plan

Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

NAMENDA
Prior Authorization Form

Namenda, Aricept (Donepezil), Exelon (Rivastigmine), Razadyne (Galantamine)

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Diagnosis:		Date Diagnosed:
Does the patient have a history of Alzheimer's Dementia?	□ Yes □ No	If YES, what is the severity of the dementia? □ Mild □ Moderate □ Severe
Does the patient have a diagnosis of dementia associated with Parkinson's Disease?	□ Yes □ No	If YES, what is the severity of the dementia? □ Mild □ Moderate □ Severe

From the patient history or exam, is there evidence of the following:

Memory loss? □ Yes □ No
Other cognitive changes? □ Yes □ No
Mood/behavior changes? □ Yes □ No
If Yes, list changes:_____

Does the patient have difficulty with daily functions?	□ Yes □ No
Has the patient's social support system been evaluated?	□ Yes □ No

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Please list cognitive test(s) performed with the date and results: (i.e. Mini-Mental, DAS cog, 3-Item Recall, etc.)		
Test Name	Date	Results

Please provide any additional information which should be considered in the space below: