ARICEPT (donepezil), EXELON (rivastigmine), RAZADYNE (galantamine), & NAMENDA

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

THIS SECTION FOR PROVIDER USE ONLY—PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:	Provider Specialty:	
Provider First Name:	Provider Last Name:	
Provider Phone:	Provider Fax:	Provider NPI #:

Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested: ❑ Brand ❑ Generic	Strength:	Frequency:	Qty Dispensed:

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

Diagnosis:	Date of diagnosis:	
❑ New Medication ❑ Ongoing Medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy? ❑Yes ❑No

Medical History:

Question	Answer	Severity
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

If NO, please specify the primary indication of the medication:

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

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

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

Test Name:	Date:	Results:

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

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