

ARICEPT/EXELON/RAZADYNE/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:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty Dispensed:
Diagnosis:			Date of diagnosis:
<input type="checkbox"/> New Medication <input type="checkbox"/> Ongoing Medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical History:			
Does the patient have a history of Alzheimer's Dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what is the severity of the dementia? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Does the patient have a diagnosis of dementia associated with Parkinson's Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what is the severity of the dementia? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe If NO, please specify the primary indication of the medication:	
From the patient history or exam, is there evidence of:			
Memory loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood/behavior changes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other cognitive changes?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient's social support system been evaluated?	<input type="checkbox"/> Yes <input type="checkbox"/> No		