



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Alzheimer's Agents**

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Does the patient have a history of therapeutic failure, a contraindication to, or intolerance of the preferred Alzheimer's Agents (e.g., donepezil ODT, donepezil 5 mg or 10 mg tablet, galantamine tablet, galantamine ER capsule, memantine tablet, rivastigmine capsule)?

Yes

No

Q2. Is this a request for an acetylcholinesterase inhibitor when the patient has a recent paid claim for an acetylcholinesterase inhibitor (i.e., potential therapeutic duplication)?

Yes

No

Q3. For therapeutic duplication, is the patient being titrated to or tapered from another acetylcholinesterase inhibitor Alzheimer's Agent?

Yes

No

Q4. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date



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