Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**

Aricept® 23mg (donepezil)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name _____

Address _____

℞ *REFER or WRITE COMPOUND NALTREXONE PRESCRIPTION*

as directed by physician

MD _____

Signature _____

Name _____

Address _____

℞ donepezil 5mg

quantity #

sig: 1 -4 orally at bedtime

as directed by physician

Dx: ALZHEIMER'S DISEASE

ICD10: G 30.9

MD _____

Signature _____

SAMPLE

usDoctor

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone	Fax

Member Information

Last Name:	First Name
Member ID Number	DOB:

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Aricept (donepezil) Prior Authorization Form

Initial Therapy You must answer ALL of the following questions		
1. Does the patient have a diagnosis of moderate to severe Alzheimer's disease?	Y	N
2. Has the patient received at least 6 months of Aricept 10 mg or Aricept 10 mg ODT?	Y	N
3. Does the patient have a mini–mental state examination (MMSE) score between 0 – 20?	Y	N
4. Is the patient taking any of the following excluded medications: benzodiazepines, opiates, tricyclic antidepressants (except for desipramine), amphetamine-type stimulants, oxybutynin, antiparkinson's drugs, theophylline, caffeine or caffeine-containing medications, long acting beta agonists, hypnotics (such as zolpidem, eszopiclone, zaleplon, ramelteon), barbiturate hypnotics (such as seconal) tramadol, doxepin, mirtazapine, trazodone, buspirone, meprobamate, or meprobamate-combinations?	Y	N

Renewal Therapy You must answer ALL of the following questions		
1. Is the patient taking any of the following excluded medications: benzodiazepines, opiates, tricyclic antidepressants (except for desipramine), amphetamine-type stimulants, oxybutynin, antiparkinson's drugs, theophylline, caffeine or caffeine-containing medications, long acting beta agonists, hypnotics (such as zolpidem, eszopiclone, zaleplon, ramelteon), barbiturate hypnotics (such as seconal) tramadol, doxepin, mirtazapine, trazodone, buspirone, meprobamate, or meprobamate-combinations?	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: _____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at the numbers found on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION FORM:
COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	

DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			

PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.

Medication/Failure Reason:

IgE:_____

ESR:_____ **CRP:**_____ **# Joints:**_____ **%BSA:**_____

Height:_____ **Weight:**_____ **BMI:**_____

HA1C:_____ **Hemoglobin:**_____ **Hematocrit:**_____ **T-Score:**_____

Dialysis:_____ **Long Term Care Facility:**_____ **Self Injecting:**_____

Stimulation test:_____/_____ **Growth velocity:**_____ **#Chemotherapy cycles/month:**_____

Mini-Mental Status Test:_____ **Baseline Free testosterone/Total testosterone:**_____/_____

HCV RNA viral load:_____ **Viral Genotype:**_____ **ALT:**_____

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	