

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice® HealthPlan

Patient Information	
<b>Name:</b>	<b>Insurance ID #:</b>
<b>Address:</b>	<b>Birthdate:</b>

Provider Information	
<b>Physician's Name:</b>	<b>Physician DEA #:</b>
<b>Phone:</b>	<b>Fax:</b>
<b>Office Address:</b>	
<b>Diagnosis:</b>	<b>ICD-9 Code:</b>

**When this form is completed, please fax back to Caremark at 1-888-836-0730.**

This fax machine is located in a HIPAA-compliant, secure location.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

*On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program.*

*Caremark is an independent company that administers prescription drug benefits.*

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|--|----------------------------|----------------------------|
| 1. Does the patient have the diagnosis of dementia of the Alzheimer's type?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Is the dementia classified as mild to moderate?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Has the patient received 12 months of therapy with the requested medication?<br>[If the answer is Yes, then go to question 5.]  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Has the patient been given a mental assessment test using a standardized scale?<br>[e.g., ADAS-COG (Alzheimer's Disease Assessment Scale) or MMSE (Mini Mental State Exam)] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Has the patient been given a mental assessment test using a standardized scale within the last 12 months? [e.g., ADAS-COG, MMSE, CIBIC-PLUS]                                | <input type="checkbox"/> Y | <input type="checkbox"/> N |

**Comments:** \_\_\_\_\_

*Information on this form is accurate as of the date below.*

<b>Prescriber's Signature:</b>	<b>Date:</b>
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