

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice[®] HealthPlan

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

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

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

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

Call Caremark at 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.

1. Does the patient have a diagnosis of moderate to severe dementia of the Alzheimer's type?

Y
 N
2. Has the patient been receiving Namenda within the previous 6 months? [If the answer to this question is yes, then skip to question 4.]

Y
 N
3. Has the patient had a comprehensive assessment in the previous 6 months, including a validated cognitive assessment {such as the Mini-Mental State Exam (MMSE-adjusted for age/education), Alzheimer's Disease Assessment Scale, Cognitive Subsection (ADAS-Cog), Blessed Information-Memory Concentration Test (BIMC), Cambridge Cognitive Examination (CAMCog), etc.} that supports the diagnosis of moderate to severe dementia of the Alzheimer's type? [No further questions are required.]

Y
 N
4. Since the last approval, has the prescriber assessed whether the drug continues to provide benefits to the patient in terms of preservation of activities of daily living or meaningful improvements in quality of life?

Y
 N

Comments: _____

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

Prescriber's Signature:	Date:
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