

ALZHEIMER'S AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Alzheimer's Agents and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength:	
Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	DX code (required):	

INITIAL requests

Is the beneficiary's diagnosis listed in either the medication's package insert OR nationally recognized compendia for the determination of medically accepted indications for off-label uses?

- Yes – *Submit documentation of diagnosis.*
 No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*

Requests for NON-PREFERRED agents only: Please list the preferred Alzheimer's Agents that the beneficiary has had a therapeutic failure on, contraindication to, or intolerance to. Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.

RENEWAL requests

Does the beneficiary have a documented rationale for continuing the requested medication?

- Yes – *Submit medical record documentation.*
 No

Please submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:

Date:

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