

## ALZHEIMER'S AGENTS

### I. I. Requirements for Prior Authorization of Alzheimer's Agents

#### A. Prescriptions That Require Prior Authorization

Prescriptions for Alzheimer's Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Alzheimer's Agent. See the Preferred Drug List (PDL) for the list of preferred Alzheimer's Agents at: <https://papdl.com/preferred-drug-list>.
2. An acetylcholinesterase inhibitor Alzheimer's Agent when there is a record of a recent paid claim for another acetylcholinesterase inhibitor Alzheimer's Agent (therapeutic duplication).

#### B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Alzheimer's Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Alzheimer's Agent, has a history of therapeutic failure, contraindication, or intolerance of the preferred Alzheimer's Agents; **AND**
2. For therapeutic duplication, **one** of the following:
  - a. Is being titrated to or tapered from another acetylcholinesterase inhibitor Alzheimer's Agent
  - b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

#### C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Alzheimer's Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

## ALZHEIMER'S AGENTS PRIOR AUTHORIZATION FORM

<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:
Medication will be billed via: <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medical (Jcode: _____)				Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's Office <input type="checkbox"/> Home <input type="checkbox"/> Other	

### 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

<b><u>Requests for NON-PREFERRED agents only:</u></b> Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Alzheimer's Agents? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred drugs in this class.	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of medication regimens tried and treatment results, contraindications, and/or intolerances.</i>
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#### RENEWAL requests

Does the beneficiary have a documented rationale for continuing the requested medication?	<input type="checkbox"/> Yes – <i>Submit medical record documentation.</i> <input type="checkbox"/> No
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### PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date:
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