Gateway Health
It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

ALZHEIMER'S AGENTS

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 prescription for a preferred or non-preferred Alzheimer's Agent. See Preferred Drug List (PDL) for the list of preferred Alzheimer's Agents at: https://papdl.com/preferred-drug-list.

2. A prescription for an Acetylcholinesterase Inhibitor when there is a record of a recent paid claim for another Acetylcholinesterase Inhibitor.

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 the following:

1. For either a preferred or non-preferred Alzheimer's Agent:

   a. Whether the recipient's diagnosis is:

      i. Indicated in the package insert

      OR

      ii. Listed in nationally recognized compendia for the determination of medically-accepted indications for off-label uses

      OR

      iii. Supported by peer reviewed medical literature provided by the prescriber

AND

2. For a non-preferred Alzheimer's Agent, whether the recipient has a history of therapeutic failure, contraindication, or intolerance of the preferred Alzheimer's Agents.

AND

3. For therapeutic duplication, whether:

   a. The recipient is being titrated to, or tapered from, another Acetylcholinesterase Inhibitor

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OR

b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested

OR

4. Whether the recipient 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 recipient.

FOR RENEWALS OF PRESCRIPTIONS for an Alzheimer's Agent - The determination of medical necessity of requests for prior authorization of renewals of prescriptions for Alzheimer's Agents that were previously approved will take into account whether the recipient has a documented rationale for continuing the medication.

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 the request for 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 recipient.

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ALZHEIMER'S AGENTS PRIOR AUTHORIZATION FORM

☐New request ☐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: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ 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 *(submit documentation)*:	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: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Alzheimer's Agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes ☐No *Submit documentation of medication regimens tried and treatment results, contraindications, and/or intolerances.*
RENEWAL requests	
Does the beneficiary have a documented rationale for continuing the requested medication?	☐Yes – *Submit medical record documentation.* ☐No

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: