



Updated: 08/2019
DMMA Approved: 08/2019

**Request for Prior Authorization for Cholinesterase Inhibitors and Memantine
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158**

All requests for Cholinesterase Inhibitors and Memantine require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Cholinesterase Inhibitors and Memantine Prior Authorization Criteria:

Coverage may be provided with a diagnosis of Alzheimer's disease and the following criteria is met:

- Must provide documentation of a Mini Mental State Exam (MMSE) with a score ≤ 26
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
 - These medications will be automatically reauthorized when the member has been consistently receiving the medication as verified by pharmacy claims, and if the member has not refilled the medication in the last 45 days, the initial criteria will apply

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

**CHOLINESTERASE INHIBITORS AND MEMANTINE
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: at a pharmacy **OR**
 medically (if medically please provide a JCODE: _____)

Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: Alzheimer's dementia Other: _____ ICD-10 code: _____
Mini-mental status exam (MMSE) score: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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