Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

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.

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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	
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 HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date:

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