FORM # FRX014

Prior Authorization Request Form for Alzheimer's Type Dementia

Razadyne(Reminyl)/Aricept/Namenda/Exelon

Member Information

Patient Name ____________________________

Cardholder ID ___________________________

Date of Birth ___________________________

Address ________________________________

City, State Zip __________________________

Phone Number ___________________________

Provider Information

Provider Name ___________________________

DEA Number _____________________________

Address ________________________________

City, State and Zip _______________________

Phone Number ___________________________

FAX Number _____________________________

Pharmacy Information

Pharmacy Name___________________Address__________________ Phone_________________________

Name and strength of drug being requested:____

Criteria for Approval:

1. Does the patient have a diagnosis of Alzheimer's type dementia? Yes☐ No ☐
2. The Alzheimer's dementia can be classified as (*Check One):*
   Mild ☐ Moderate ☐ Severe ☐
3. Has the patient been on the drug being requested for the previous 6 months? Yes☐ No ☐
4. Has the patient been evaluated with the Mini-Mental State Exam (MMSE) cognitive status assessment within the previous 3-6 months? Yes☐ No ☐
5. Has the rate of cognitive status deterioration further declined since initial treatment or since the Mini-Mental State Exam? Yes☐ No ☐

Provider Signature ____ Date_________________

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received____

Reference Number____

Approved / Denied (Circle One) by ____________________________________ Date________________________

Date/Time Returned to Provider____

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If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or Fax Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375 -1 Capital Circle NE
Tallahassee, FL 32308

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