**Prior Authorization Form**

# CAREMARK FAX FORM

## Aricept

**This fax machine is located in a secure location as required by HIPAA regulations.**
**Complete information, sign and date. Fax completed forms to Caremark at 1-888-836-0730**

**Please contact Caremark @ 1-888-414-3125 with questions regarding the prior authorization process.**

**When conditions are met, we will authorize the coverage of Aricept**

***Drug Name:*** ______________________________

**Patient:**
**Patient Name:** ______________________________
**Patient ID:** ______________________________
**Patient Group Number:** ______________________________
**Patient Date Of Birth:** ______________________________

***Prescribing Physician:***

**Physician Name:** ______________________________
**Physician Phone:** ______________________________
**Physician Fax:** ______________________________
**Physician** ______________________________
**Physician City, State, Zip:** ______________________________

**Diagnosis:** **ICD 9 code:**

Please circle the appropriate answer for each applicable question.

1 Does the patient have a diagnosis of dementia of the Alzheimer`s type? Y N

[If the answer to this question is yes, then skip to question 4.]

2 Does the patient have a diagnosis of dementia associated with Parkinson`s Disease? Y N

[If the answer to this question is yes, then skip to question 4.]

3 Does the patient have a diagnosis of vascular dementia? Y N

[If the answer to this question is no, then no further questions are required.]

4 Has the patient been receiving Aricept within the previous 6 months? Y N

[If the answer to this question is yes, then skip to question 7.]

5 Has the patient had a comprehensive assessment in the previous 6 months, including a validated cognitive assessment [such as the Mini-Mental State Exam (MMSE-adjusted for age/education), Alzheimer`s Disease Assessment Scale, Cognitive Subsection

(ADAS-Cog), Blessed Information-memory Concentration Test (BMIC), Cambridge Cognitive Examination (CAMCog), etc.], that supports the diagnosis of dementia of the Alzheimer`s type, dementia associated with Parkinson`s Disease, or vascular dementia? Y N

6 Is the patient hyper-sensitive to piperidine-derived medications such as methylphenidate, biperiden hydrochloride, trihexyphenidyl hydrochloride, or paroxetine hydrochloride? Y N

[No further questions are required.]

7 Since the last approval, has the prescriber assessed (through a comprehensive set of evaluations including standard cognitive assessments like CAMCog, MMSE, ADAS-Cog, BIMC, etc.) whether the drug continues to provide benefits to the patient in terms

of ADLs (Activities of Daily Living) / IADLS (Instrumental Activities of Daily Living)? Y N

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Comments: ______________________________

*Information given on this form is accurate as of this date.*

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**Prescriber or Authorized Signature**