Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Aricept

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Aricept.

Drug Name (select from list of drugs shown)

Aricept (donepezil) | Aricept ODT (donepezil) | Donepezil | Donepezil ODT

Quantity | Frequency | Strength

Route of Administration | Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have any of the following diagnoses, supported by a validated cognitive assessment within the past 12 months: A) dementia of the Alzheimer's type, B) dementia associated with Parkinson's disease, C) vascular dementia? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date