Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Razadyne

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 Razadyne.

Drug Name (select from list of drugs shown)

Galantamine	Razadyne (galantamine)	Razadyne ER (galantamine)
Razadyne Solution (galantamine)	Razadyne Tablet (galantamine)	

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: mild to moderate dementia of the Alzheimer's type OR 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