Prior Authorization Form

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 **1-855-582-2022** 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 attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is

available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date