

Prior Authorization Form

Exelon (HMF)

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 Exelon (HMF).

Drug Name (select from list of drugs shown)

Rivastigmine Cap

Rivastigmine TD Patch

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) mild to moderate dementia associated with Parkinson's disease, C) dementia with Lewy bodies?

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