TRICARE Prior Authorization Request Form for
donepezil transdermal system (Adlarity)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Is the requested medication being prescribed by a neurologist, psychiatrist, or specialist in geriatric medicine?	☐ Yes Proceed to question 3	☐ No **STOP** Coverage not approved
3. Is the patient being treated for mild, moderate, or severe dementia of the Alzheimer's type?	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
4. Has the patient tried and failed, has a contraindication to, or has had an adverse reaction to one oral donepezil formulation (for example, donepezil 5 mg or, 10 mg tab or orally dissolving tablets [ODT])?	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Has the patient tried and failed, has a contraindication to, or has had an adverse reaction to one topical agent: rivastigmine transdermal system (Exelon patch)?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[9 September 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: