Prior Authorization Request Form for
Memantine ER (Namenda XR)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

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 being treated for moderate to severe Alzheimer's or mixed dementia (Alzheimer's disease plus vascular dementia)?	☐ Yes **Proceed to question 2**	☐ No STOP **Coverage not approved**
2. Has the patient tried Namenda IR (memantine)?	☐ Yes **Proceed to question 3**	☐ No STOP **Coverage not approved**
3. Does taking Namenda IR (memantine) twice daily cause undue burden to the patient or care provider?	☐ Yes **Proceed to question 4**	☐ No STOP **Coverage not approved**
4. Has the patient's functional status declined while receiving Namenda IR?	☐ Yes **STOP Coverage not approved**	☐ No **Sign and date below**

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

_____ _____
Prescriber Signature Date

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: