Prior Authorization Request Form for
Donepezil/memantine (Namzaric)

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 being treated for moderate to severe dementia of the Alzheimer's type?	☐ Yes **Proceed to question 2**	☐ No STOP **Coverage not approved**
2. Is the patient stabilized on memantine IR 10 mg twice daily or memantine ER 28 mg once daily and donepezil hydrochloride 10 mg?	☐ Yes **Proceed to question 4**	☐ No **Proceed to question 3**
3. Is the patient stabilized on memantine IR 5 mg twice daily or ER 14 mg once daily and donepezil hydrochloride 10 mg?	☐ Yes **Proceed to question 4**	☐ No **STOP Coverage not approved**
4. Is the patient unable to take Namenda (memantine) and Aricept (donepezil) separately?	☐ Yes **Sign and date below**	☐ No **Proceed to question 5**
5. Does the patient have progressive swallowing difficulties?	☐ 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

[03 February 2016]

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