Prescriber Criteria Form

Namenda 2024 PA Fax 1439-B v1 010124.docx
Namenda (All Dosage Forms) (memantine hydrochloride)
Prior Authorization Applies Only To Patients Less Than 30 Years Of Age.
Coverage Determination

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 **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Namenda (All Dosage Forms) (memantine hydrochloride).

Drug Name:
Namenda (All Dosage Forms) (memantine hydrochloride)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

CRITERIA FOR APPROVAL

1	Does the patient have a diagnosis of moderate to severe dementia of the Alzheimer's type?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____