

MedStar Medicare Choice Pharmacy Services Phone: 855-266-0712

Fax: 855-862-6517

Revised: 10/2016

MEMANTINEPrior Authorization Form

Please note PA is not required for patients over 40 years of age, only for patients 40 or younger. Also, if request is for Namenda XR, that product is non-formulary and requires a covered diagnosis and a statement of medical necessity as to why formulary immediate release memantine cannot be utilized*

□ Standard Request (72 hours)□ Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

	requesting	reimbur		a drug you already rece	eived.			
			Den	nographics				
Patient Information					Prescribe	Prescriber Information		
Patient Name:				Prescriber Name:				
DOB:		Age	э:	NPI#:	NPI#:		Specialty:	
Health Plan ID#:				Phone:		Fax:		
Pharmacy Name: Pha		harmacy Phone:		Office Contac	Office Contact:		Direct Phone # or Ext:	
		Λ	/ledicati	ion Information	1			
Drug Requested:			Strengt		Directions:			
Quantity Dispensed:			Day Su	pply:	y:		☐ Generic☐ Brand Necessary	
Generic equivale	ent drugs will be	substit	tuted for B	rand name drugs uni	less you specific	ally indic	cate otherwise.	
□ New medication□ Continuation of therapy Start Date:						therapy, please provide CHART DOCUMENTATION showed improvement while on therapy.		
			Clinica	al Information				
Diagnosis:							ignosed:	
Please provide any	additional	infor	rmation	which should	be conside	red in	the space below:	