{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the diagnosis?
   - ❑ Parkinson's disease psychosis
   - ❑ Dementia-related psychosis
   - ❑ Other, please specify_____
2. What is the ICD-10 code? _____
3. Is the requested medication prescribed for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis? ❑ Yes ❑ No
4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to # 6*
5. Has the patient experienced an improvement in psychotic symptoms (hallucinations and/or delusions) since starting therapy? ❑ Yes ❑ No *No further questions.*
6. What level of cognitive impairment does the patient exhibit as determined by physician's clinical diagnosis and/or cognitive impairment screening tests (e.g., Mini-Mental Status Examination [MMSE], Montreal Cognitive Assessment [MoCA])?
   - ❑ No cognitive impairment
   - ❑ Mild cognitive impairment
   - ❑ Moderate cognitive impairment
   - ❑ Severe cognitive impairment
   - ❑ Other/Undetermined, please specify (if applicable):_____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____
Prescriber (Or Authorized) Signature and Date