Prescriber Criteria Form

Namenda 2025 PA Fax 1439-B v1 010125.docx
Namenda (memantine), Namenda XR (memantine extended release)
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.

Drug Name (select from list of drugs shown):

| | | |
|---|---|---|
| **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.** | | | |
|---|---|---|---|
| | | | |
| 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:**_____