10181 Scripps Gateway Court
San Diego, CA 92131

Phone: (800) 788-2949
Fax: (858) 790-7100

High-Risk Medications in the Elderly Prior Authorization Request Form

This form can be used to request high risk medications, including the following:

- Anticholinergics (e.g. benztropine, cyproheptadine, diphenhydramine, promethazine), Barbiturates (e.g. Esgic, Margesic, Zebutal, Capacet, Fiorinal, Fioricet with codeine, Tencon, Allzital), Benzodiazepines (e.g. estazolam, Restoril, Halcion, flurazepam), Cardiovascular Agents (e.g. Tenex, Procardia, nifedipine, methyldopa-hctz, methyldopa, digoxin), CNS agents (e.g. meprobamate), Lomotil, estrogens, sulfonylureas (e.g. chlorpropamide, glyburide, glyburide/metformin), indomethacin, ketorolac, meclizine, paroxetine, phenobarbital, and tricyclic antidepressants (e.g. desipramine, doxepin, imipramine, nortriptyline).

Patient Information		**Prescriber Information**		
Patient Name:		Prescriber Name:		
Member ID#		DEA#	NPI#	
Address:		Address:		
City:	State	City:		State:
Home Phone:	Zip:	Office Phone:	Office Fax:	Zip:
Sex (circle): M F	DOB:	Contact Person:		

Diagnosis and Medical Information			
Medication:	Directions for use: (Frequency & Strength):		
☐ New Prescription OR Date Therapy Initiated:	Expected Length of Therapy: Route of Administration:	Qty: Qty per month:	
Height/Weight:	Drug Allergies:	Diagnosis:	
Prescriber's Signature:	MD Specialty	Date:	

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Documentation of Medical Necessity:

1. Is the requested medication going to be used for an FDA approved indication? ☐ Yes ☐ No
2. Is the patient enrolled in hospice? ☐ Yes ☐ No
3. Does the prescriber acknowledge or is aware that The American Geriatrics Society (AGS) considers the requested medication to be of high risk for patients 65 years old or older?
   ☐ Yes ☐ No
4. Please indicate other medications tried and/or failed (be specific, give detail): _____
   _____
   _____
5. Reason for medication request (be specific; give details and symptoms treated):
   _____
   _____
   Other information pertinent to this request:_____

Request for Expedited Review

☐ **REQUEST FOR EXPEDITED REVIEW [24 HOURS]**

- BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA.