ANTIDEMENTIA DRUGS SUMMARY

<table>
<thead>
<tr>
<th>PREFERRED</th>
<th>Donepezil, Donepezil ODT, Exelon capsules (brand), Exelon 2 mg/ml oral solution, Exelon transdermal patch, Galantamine tablets, Galantamine ER capsules, Namenda oral solution/tablets, Razadyne oral solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-PREFERRED</td>
<td>Aricept 23mg, Galantamine oral solution, Namenda XR capsules, Rivastigmine capsules</td>
</tr>
</tbody>
</table>

LENGTH OF AUTHORIZATION: 1 Year

PA CRITERIA:

For Aricept 23mg
- Approvable for moderate to severe Alzheimer’s Disease in members who have been taking Aricept 10mg once daily for 3 or more months or for members who are already stabilized on the Aricept 23mg dosage form

For Galantamine oral solution
- Submit a written letter of medical necessity stating the reason(s) the preferred product, brand-name Razadyne oral solution, is not appropriate for the member.

For Namenda XR
- Submit a written letter of medical necessity stating the reason(s) the preferred product, Namenda regular strength tablets or oral solution, is not appropriate for the member.

For Rivastigmine capsules
- Submit a written letter of medical necessity stating the reason(s) the preferred product, brand-name Exelon capsules, is not appropriate for the member.

EXCEPTIONS:
- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling Catamaran at 1-866-525-5827.

PA and Appeal Process:
- For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

Quantity Level Limitations:
- For online access to the current Quantity Level Limits please go to www.mmis.georgia.gov/portal, highlight Provider Information and click

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on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.