



ANTIDEMENTIA DRUGS SUMMARY

PREFERRED	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
NON-PREFERRED	Aricept 23mg, Galantamine oral solution, Namenda XR capsules, Rivastigmine capsules

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



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