

Prescriber Criteria Form

HRM Antiparkinson 2026 PA Fax 3611-B v1 010126.docx
 High Risk Medications (HRM) Criteria – Antiparkinson Agents
 Benztropine oral, trihexyphenidyl
 This HRM List applies to formulary drugs only
 Prior Authorization applies only to patients 65 years of age or older.
 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 Antiparkinson Agents.

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	Is the requested drug being prescribed for the treatment of extrapyramidal symptoms (EPS)? [If no, then skip to question 7.]	Yes	No
2	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Has the patient tried the non-HRM (non-High Risk Medication) alternative drug amantadine? [If yes, then skip to question 4.]	Yes	No
3	Does the patient have a contraindication to the non-HRM (non-High Risk Medication) alternative drug amantadine? [If yes, then skip to question 6.] [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response to the non-HRM (non-High Risk Medication) alternative drug amantadine? [If yes, then skip to question 6.]	Yes	No

5	Has the patient experienced an intolerance to the non-HRM (non-High Risk Medication) alternative drug amantadine? [If no, then no further questions.]	Yes	No
6	Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient? [If yes, then skip to question 11.] [If no, then no further questions.]	Yes	No
7	Is the requested drug being prescribed for the treatment of Parkinson's disease? [If no, then no further questions.]	Yes	No
8	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Has the patient tried two of the following non-HRM (non-High Risk Medication) alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole? [If no, then no further questions.]	Yes	No
9	Has the patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM (non-High Risk Medication) alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole? [If no, then no further questions.]	Yes	No
10	Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient? [If no, then no further questions.]	Yes	No
11	Is the patient using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug? [If no, then no further questions.]	Yes	No
12	Has the prescriber determined that taking multiple anticholinergic medications is medically necessary for the patient? [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]	Yes	No

Comments:	
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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: _____
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