Prescriber Criteria Form
Polypharmacy ACH 2026 PA Fax 6826-B v1 010126.docx
Amoxapine, Dicyclomine, Nortriptyline, Paroxetine, Perphenazine, Perphenazine-Amitriptyline, Prochlorperazine
Prior Authorization only applies 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 Amoxapine, Dicyclomine, Nortriptyline, Paroxetine, Perphenazine, Perphenazine-Amitriptyline, Prochlorperazine.

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 patient using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug? [If no, then no further questions.]	Yes	No
2	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:	_____

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:**_____