Service Request Form / Long Term Care

Please complete and fax the Service Request Form to (214) 884-7007.

This form should be completed by a prescribing physician, nurse, or facility pharmacist to request prior authorization or appeals support. It does not initiate treatment.

1. Facility and Prescriber Information

**Indicates required field*

*Facility Name	*Facility City
*Facility State	Pharmacy

*Prescriber Name		*Prescriber NPI Number
*Person Submitting Form	◯ Prescriber ◯ Authorized Agent	*Name of Authorized Agent (if applicable)
*Prescriber or Authorized Agent Phone #		*Prescriber or Authorized Agent Email Address
ZUNVEYL Sales Representative (if known)		

Please note: You may list up to 10 residents on this form from the same facility and prescriber above. A new form must be submitted for a different facility and/or prescriber.

2. Resident Information

Resident 1	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 2	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 3	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 4	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 5	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 6	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 7	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 8	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 9	*First Name	*Last Name	*DOB (MM/DD/YYYY)
Resident 10	*First Name	*Last Name	*DOB (MM/DD/YYYY)

3. Prescriber Authorization

To be completed by prescribing physician, nurse, or facility pharmacist

*Prescriber or Authorized Agent (e.g. nurse) Signature (no stamp allowed)
*Date

Prescriber Authorization: I attest that I have obtained written permission, in the event it is required under applicable federal and/or state law, of my patient (or the patient's legal representative) for the release of my patient's Protected Health Information ("PHI") to Alpha Cognition Inc. or its representatives or agents (collectively "Alpha Cognition") as may be necessary for the patient's participation in a program designed to assist patients in determining their insurance coverage for ZUNVEYL that I have elected to prescribe. I direct Alpha Cognition to convey, on my behalf, any prescription information delivered to Alpha Cognition for ZUNVEYL by any means under applicable law to the dispensing pharmacy chosen by or for the patient, to the patient's health insurance company, or to other third parties as may be necessary to assist this patient with filling his/her prescription for ZUNVEYL, with securing any insurance coverage for ZUNVEYL to which the patient is entitled, or other third parties to assist with patient assistance or reduced-cost medication. I understand I am to comply with the state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. I agree that Alpha Cognition may contact me for additional information relating to ZUNVEYL, including but not limited to via email, fax, and telephone. I authorize Alpha Cognition to transmit the above prescription to the pharmacy.

Alpha Cognition

ZUNVEYL
(benzgalantamine)
DELAYED RELEASE TABLETS
5 mg | 10 mg | 15 mg