Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

# Aptensio™ XR Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Attention deficit hyperactivity disorder (ADHD)/Attention deficit disorder (ADD)
*Please complete corresponding section below and submit any documentation as requested*

❑ Narcolepsy
*Please submit documentation (i.e., polysomnography and MSLT) to support diagnosis*

❑ Other diagnosis:_____ ICD-10 Code(s): _____
*Please submit documentation (i.e., chart notes, previous therapies tried) to support diagnosis*

***Please note: Non-FDA approved indications - Submit two (2) peer reviewed clinical studies documenting the safety and efficacy of the specified drug for that particular indication.***

**Attention deficit hyperactivity disorder (ADHD)/Attention deficit disorder (ADD):**

Select if there is documentation of one of the following:

❑ Existence of 5 or more Inattentive Symptoms for a minimum of 6 months

❑ Existence of 5 or more Hyperactive-Impulsive Symptoms for a minimum of 6 months

❑ Existence of 10 or more Combined Symptoms for a minimum of 6 months (including 5 or more inattentive symptoms AND 5 or more hyperactive-impulsive symptoms)

Is there documentation that symptoms impair or compromise normal functioning? ❑ **Yes** ❑ **No**

Is there documentation that symptoms are present in two (2) or more settings/environments? ❑ **Yes** ❑ **No**

If **yes**, indicate the settings: 1._____ 2. _____

Are the patient's symptoms better explained by another disorder (e.g., Schizophrenia, Mood Disorder, Anxiety Disorder, Substance Abuse, Dissociative Disorder, or Personality Disorder)? ❑ **Yes** ❑ **No**

Has the provider submitted the patient-specific DSM symptoms, criteria, psychological evaluation, and/or standardized rating scale used to make or verify the diagnosis? ❑ **Yes** ❑ **No**

*Please note: The patient-specific DSM symptoms, criteria, psychological evaluation, and/or standardized rating scale used to make or verify the diagnosis must be submitted with this form for approval*

**Select if the patient has tried and failed <u>30 days</u> of therapy with the following medications:**

❑ Amphetamine-dextroamphetamine extended-release (generic Adderall XR)

❑ Methylphenidate CR (generic Metadate CD)

❑ Methylphenidate SR (generic Ritalin LA)

❑ Vyvanse

# Aptensio™ XR Prior Authorization Request Form (Page 2 of 2)

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**Quantity limit requests:**

What is the quantity requested per DAY? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

*** Please note: Chart documentation of the above is required to be submitted along with this fax*

_____

_____

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

***Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***

**Prescriber Signature:** _____ **Date:** _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.