

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

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Attention deficit hyperactivity disorder (ADHD)/Attention deficit disorder (ADD)  <i>Please complete corresponding section below and submit any documentation as requested</i></p> <p><input type="checkbox"/> Narcolepsy  <i>Please submit documentation (i.e. polysomnography and MSLT) to support diagnosis</i></p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____  <i>Please submit documentation (i.e. chart notes, previous therapies tried) to support diagnosis</i></p> <p><b>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.</b></p>					
<p><b>Attention deficit hyperactivity disorder (ADHD)/Attention deficit disorder (ADD):</b></p> <p>Is there documentation that symptoms impair or compromise normal functioning? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there documentation that symptoms are present in two (2) or more settings/environments? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, indicate the settings: 1. _____ 2. _____</p> <p>Is there documentation of inattentive or hyperactive-impulsive symptoms <u>before the age of 12</u>? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, indicate the source below (if available):</p> <p><input type="checkbox"/> Corroborated by a relative/friend</p> <p><input type="checkbox"/> Medical Chart/Progress Notes documenting childhood diagnosis and/or symptoms</p> <p><input type="checkbox"/> School Records</p> <p><input type="checkbox"/> Not Available</p> <p>Are the patient's symptoms better explained by another disorder (e.g. Schizophrenia, Mood Disorder, Anxiety Disorder, Substance Abuse, Dissociative Disorder, or Personality Disorder)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the provider submitted the patient-specific DSM symptoms, criteria, psychological evaluation, and/or standardized rating scale used to make or verify the diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>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</i></p>					
<p><b>Select if the patient has tried and failed <u>30 days</u> of therapy with the following medications:</b></p> <p><input type="checkbox"/> Amphetamine-dextroamphetamine extended-release (generic Adderall XR)</p> <p><input type="checkbox"/> Methylphenidate CR (generic Metadate CD)</p> <p><input type="checkbox"/> Methylphenidate SR (generic Ritalin LA)</p> <p><input type="checkbox"/> Vyvanse</p>					



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



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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.