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

CNS Stimulants 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 requested drug below:

- ❑ Amphetamine-dextroamphetamine (Adderall)
- ❑ Amphetamine-dextroamphetamine ER (Adderall XR)
- ❑ Cotempla XR-ODT
- ❑ Daytrana
- ❑ Dexmethylphenidate (Focalin)
- ❑ Dexmethylphenidate ER (Focalin XR)
- ❑ Dextroamphetamine ER (Dexedrine)
- ❑ Dextroamphetamine solution (Procentra)
- ❑ Dextroamphetamine tablet (Zenzedi)
- ❑ Metadate ER
- ❑ Methamphetamine (Desoxyn)
- ❑ Methylphenidate (Ritalin)
- ❑ Methylphenidate chewable tablet
- ❑ Methylphenidate ER (Concerta)
- ❑ Methylphenidate ER capsule (Ritalin LA)
- ❑ Methylphenidate ER tablet
- ❑ Methylphenidate solution (Methylin)
- ❑ Mydayis
- ❑ Vyvanse capsule
- ❑ Vyvanse chewable tablet

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

CNS Stimulants 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.