

Prior Authorization Request Form for Amphetamine/Methylphenidate Products

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name _____ Address _____ Phone _____

Name of drug and strength requesting: _____

Criteria for Approval:

1. If requesting an Amphetamine product, is the patient 3 years of age or older? Yes No

OR

If requesting a Methylphenidate product, is the patient 6 years of age or older? Yes No

2. Has the patient been on an Amphetamine/D-Amphetamine or a Methylphenidate product for the previous 6 months? Yes No
3. Diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD)? Yes No
4. Diagnosis of Narcolepsy? Yes No
5. Have any of the following requirements been met? *Check all that apply:* Yes No
- ADHD symptoms displayed in more than one setting (i.e., school, work, home, etc)
 - ADHD symptoms displayed for at least 6 months
 - ADHD symptoms significantly impair social, academic, or occupational functioning
 - No other psychiatric disorders to explain hyperactivity
 - Narcolepsy confirmed in sleep studies
 - No other extraneous causes for excessive daytime sleepiness (i.e., depression, insufficient sleep syndrome, nighttime insomnia, or upper airway resistance syndrome)

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received _____

Reference Number _____

Approved / Denied (Circle One) by _____ Date _____

Date/Time Returned to Provider _____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-1 Capital Circle NE
Tallahassee, FL 32308

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