



Prior Authorization Request Form - Attention Deficit Hyperactivity Disorder Drugs (ADHD)

Instructions:

This form is to be used by participating providers to request coverage for drugs requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners - Prior Authorization Services
P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
Fax: 1-800-918-7542

An Attention Deficit Hyperactivity Disorder (ADHD) drug step therapy program has been developed to encourage the use of 1 st -line therapies before 2 nd -line therapies are used for the same indication. A trial of two, 1 st -line, long-acting stimulants is required before the use of a second-line stimulant for ADHD. When approved, quantity limits apply.	
First-Line Drugs amphetamine/dextroamphetamine SR (generic Adderall XR) Vyvanse (lisdexamfetamine), methylphenidate SA (compare to Concerta) Focalin XR (dexmethylphenidate), Metadate CD (methylphenidate), Ritalin LA (methylphenidate)	Second-Line Drugs Daytrana patch (methylphenidate)
amphetamine/dextroamphetamine SR, Vyvanse, Concerta, Daytrana patch, Focalin XR, Metadate CD, Ritalin LA,	Strattera (atomoxetine) Intuniv [®] (guanfacine extended release) Kapvay [®] (clonidine extended release)

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
4. Prescriber's FULL Name & Specialty:	5. Contact Person at Office:	
6. Prescriber's FAX & Telephone Number: Fax: () Tel: ()		
Mailing Address:		
7. Requested Drug: <input type="checkbox"/> Strattera <input type="checkbox"/> Daytrana <input type="checkbox"/> Intuniv <input type="checkbox"/> Kapvay	8. Dose, Frequency, and Duration of Requested Drug:	
9. Has the member been started and stabilized (excluding samples) on the requested drug within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, duration of therapy: _____		
10. Does the member have a history of drug abuse, alcoholism, or significant tic disorder? <input type="checkbox"/> Yes Please specify: _____ <input type="checkbox"/> No		
11. Has the member previously tried the following?		
Drug Name (please check all that apply)	Response (please check all that apply)	
<input type="checkbox"/> amphetamine/dextroamphetamine SR	<input type="checkbox"/> side effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> methylphenidate SA (compare to Concerta)	<input type="checkbox"/> side effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> Focalin XR (dexmethylphenidate SR)	<input type="checkbox"/> side effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> Metadate CD (methylphenidate CR)	<input type="checkbox"/> side effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> Ritalin LA (methylphenidate SR)	<input type="checkbox"/> side effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> Strattera (atomoxetine)	<input type="checkbox"/> side effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> Vyvanse (lisdexamfetamine)	<input type="checkbox"/> side effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	
<input type="checkbox"/> guanfacine immediate release (IR)	<input type="checkbox"/> non-response <input type="checkbox"/> non-compliance to multiple dosing	
<input type="checkbox"/> clonidine immediate release (IR)	<input type="checkbox"/> non-response <input type="checkbox"/> non-compliance with 3 to 4x daily dosing	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> side effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy <input type="checkbox"/> Other: _____	
12. Does the member have a documented swallowing disorder or adherence issue with oral medications? <input type="checkbox"/> Yes, please specify: _____ <input type="checkbox"/> No		
13. Has the member tried amphetamine/dextroamphetamine SR, Ritalin LA, Metadate CD, and/or Focalin XR sprinkled on food? <input type="checkbox"/> Yes, please specify all product(s) tried and outcomes: _____ <input type="checkbox"/> No		
14. Prescriber comments:		

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature

Date