Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

ADHD Agents Post Limit

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of ADHD Agents Post Limit.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? Y N

[If no, then skip to question 14.]

2. Has the diagnosis been appropriately documented (i.e., evaluated by a complete clinical assessment, using DSM-5, standardized rating scales, interviews/questionnaires)? Y N

3. Which drug is being requested (applies to brand or generic)?

[Note: Please check which drug (applies to brand or generic).]

Adderall (amphetamine mixture) (if checked, go to 4) ☐

	Adderall XR (amphetamine extended-release mixture) (if checked, go to 4)	☐
	Adzenys ER (amphetamine extended-release oral suspension) (if checked, go to 4)	☐
	Adzenys XR-ODT (amphetamine extended-release orally disintegrating tablets) (if checked, go to 4)	☐
	Aptensio XR (methylphenidate extended-release) (if checked, go to 5)	☐
	Concerta (methylphenidate extended-release) (if checked, go to 5)	☐
	Cotempla XR (methylphenidate extended-release orally disintegrating tablet) (if checked, go to 5)	☐
	Desoxyn (methamphetamine) (if checked, go to 13)	☐
	Dexedrine Spansule (dextroamphetamine sustained-release) (if checked, go to 6)	☐
	dextroamphetamine (if checked, go to 6)	☐
	Daytrana Patch (methylphenidate transdermal system) (if checked, go to question 9)	☐
	Dyanavel XR (amphetamine extended-release oral suspension) (if checked, go to question 10)	☐
	Evekeo (amphetamine sulfate) (if checked, go to 4)	☐
	Focalin (dexmethylphenidate) (if checked, go to 7)	☐
	Focalin XR (dexmethylphenidate extended-release) (if checked, go to 7)	☐
	Metadate CD (methylphenidate extended-release) (if checked, go to 5)	☐
	Methylin chewable (methylphenidate chewable tablet) (if checked, go to 8)	☐
	methylphenidate tablets (if checked, go to 8)	☐
	methylphenidate oral solution (if checked, go to 8)	☐
	methylphenidate extended-release (if checked, go to 5)	☐
	Mydayis (amphetamine extended-release mixture) (if checked, go to 4)	☐
	Procentra (dextroamphetamine sulfate oral solution) (if checked, go to 6)	☐
	QuilliChew ER (methylphenidate extended-release chewable tablets) (if checked, go to 5)	☐
	Quillivant XR (methylphenidate hydrochloride extended-release oral suspension) (if checked, go to 5)	☐

	Ritalin LA (methylphenidate extended-release) (if checked, go to 5)	☐
	Strattera (atomoxetine) (if checked, go to question 11)	☐
	Vyvanse (lisdexmfetamine) (if checked, go to question 12)	☐
	Zenzedi (dextroamphetamine) (if checked, go to 6)	☐
4.	Does the patient require use of MORE than any of the following: A) 900 ml per month of Adzenys ER, B) 180 units per month of Evekeo 5 mg, 10 mg, C) 120 units per month of Adderall 5 mg, 7.5 mg, 10 mg, 12.5 mg OR Adderall XR 5 mg, 10mg OR Adzenys XR-ODT 3.1 mg, 6.3 mg, 9.4 mg, D) 90 units per month of Adderall 15 mg, 20 mg OR Mydayis 12.5 mg, E) 60 units per month of Adderall 30 mg OR Adderall XR 15 mg, 20 mg, 25 mg, 30 mg OR Adzenys XR-ODT 12.5 mg, 15.7 mg, 18.8 mg OR Mydayis 25 mg, F) 30 capsules per month of Mydayis 37.5 mg, 50 mg?	Y N
	[No further questions.]	
5.	Does the patient require use of MORE than any of the following: A) 150 units per month of methylphenidate ER 10 mg, 20 mg OR QuilliChew ER 20 mg OR Ritalin LA 10 mg, 20 mg, B) 120 tablets per months of Cotempla XR 8.6 mg, 17.3 mg, C) 90 units per month of Aptensio XR 10 mg, 15 mg, 20 mg, 30 mg OR Concerta 18 mg, 27 mg, 36 mg OR Cotempla XR 25.9 mg OR Metadate CD 10 mg, 20 mg, 30 mg OR QuilliChew ER 30 mg OR Ritalin LA 30 mg, D) 60 units per month of Aptensio XR 40 mg, 50 mg OR Concerta 54 mg OR Metadate CD 40 mg, 50 mg OR QuilliChew ER 40 mg OR Ritalin LA 40 mg, E) 30 units per month of Aptensio XR 60 mg OR Metadate CD 60 mg OR Ritalin LA 60 mg F) 600 ml per month of Quillivant XR oral suspension 25 mg/5 ml (5 mg/1 ml).	Y N
	[No further questions.]	
6.	Does the patient require use of MORE than any of the following: A) 180 units per month of dextroamphetamine 2.5 mg, 5 mg, 7.5 mg, 10 mg OR Zenzedi 2.5 mg, 5 mg, 7.5 mg, 10 mg, B) 150 units per month of Dexedrine Spansule 5 mg, 10 mg, C) 120 units per month of dextroamphetamine 15 mg OR Dexedrine Spansule 15 mg OR Zenzedi 15 mg, D) 90 units per month of dextroamphetamine 20 mg OR Zenzedi 20 mg, E) 60 units per month of dextroamphetamine 30 mg OR Zenzedi 30 mg, F) 1,800 ml per month of ProCentra oral solution 5 mg/5 ml?	Y N
	[No further questions.]	

7. Does the patient require use of MORE than any of the following: A) 150 units per month of Focalin 2.5 mg, 5 mg, 10 mg, B) 90 units per month of Focalin XR 5 mg, 10 mg, 15 mg, C) 60 units per month of Focalin XR 20 mg, 25 mg, D) 30 units per month of Focalin XR 30 mg, 35 mg or 40 mg?	Y N
[No further questions.]	
8. Does the patient require use of MORE than any of the following: A) 300 units per month of Methylin chewable tablets 2.5 mg, 5 mg, 10 mg, B) 210 units per month of methylphenidate 5 mg, 10 mg, C) 150 units per month of methylphenidate 20 mg, D) 3,000 ml per month of methylphenidate oral solution 5 mg/5 ml, E) 1,500 ml per month of methylphenidate oral solution 10 mg/5ml?	Y N
[No further questions.]	
9. Does the patient require use of MORE than 30 patches per month of Daytrana Patch?	Y N
[No further questions.]	
10. Does the patient require use of MORE than 240 ml per month of Dyanavel XR oral suspension?	Y N
[No further questions.]	
11. Does the patient require use of MORE than any of the following: A) 120 capsules per month of Strattera 10 mg, 18 mg or 25 mg, B) 60 capsules per month of Strattera 40 mg, C) 30 capsules per month of Strattera 60 mg, 80 mg, 100 mg?	Y N
[No further questions.]	
12. Does the patient require use of MORE than 60 capsules per month of Vyvanse 10 mg, 20 mg or 30 mg OR 30 capsules per month of Vyvanse 40 mg, 50 mg, 60 mg, or 70 mg?	Y N
[No further questions.]	
13. Does the patient require use of MORE than 150 tablets per month of Desoxyn?	Y N
[No further questions.]	
14. Does the patient have a diagnosis of narcolepsy confirmed by a sleep study?	Y N
15. Is this request for amphetamine extended-release mixture (Adderall XR, Mydayis), amphetamine extended-release (Adzenys ER, Adzenys XR-ODT), methylphenidate immediate release, methylphenidate extended-release (Aptensio XR, Cotempla XR, Concerta, Metadate CD, QuilliChew ER, Quillivant XR, Ritalin LA), dexmethylphenidate (Focalin), dexmethylphenidate extended-release (Focalin XR) or methylphenidate chewable tablet (Methylin chewable tablet)?	Y N
16. Which drug is being requested (applies to brand or generic)?	

[Note: Please check which drug (applies to brand or generic).]	
Adderall (amphetamine mixture) (if checked, go to 17)	☐
Dexedrine Spansule (dextroamphetamine sustained-release) or dextroamphetamine (if checked, go to 18)	☐
Evekeo (amphetamine sulfate) (if checked, go to 17)	☐
Procentra (dextroamphetamine sulfate oral solution) (if checked, go to 18)	☐
Zenzedi (dextroamphetamine) (if checked, go to 18)	☐
17. Does the patient require use of MORE than any of the following: A) 180 units per month of Evekeo 5 mg, 10 mg, B) 120 units per month of Adderall 5 mg, 7.5 mg, 10 mg, 12.5 mg, C) 90 units per month of Adderall 15 mg, 20 mg, D) 60 units per month of Adderall 30 mg?	Y N
[No further questions.]	
18. Does the patient require use of MORE than any of the following: A) 180 units per month of dextroamphetamine 2.5 mg, 5 mg, 7.5 mg, 10 mg OR Zenzedi 2.5 mg, 5 mg, 7.5 mg, 10 mg, B) 150 units per month of Dexedrine Spansule 5 mg, 10 mg, C) 120 units per month of dextroamphetamine 15 mg OR Dexedrine Spansule 15 mg OR Zenzedi 15 mg, D) 90 units per month of dextroamphetamine 20 mg OR Zenzedi 20 mg, E) 60 units per month of dextroamphetamine 30 mg OR Zenzedi 30 mg, F) 1,800 ml per month of ProCentra oral solution 5 mg/5 ml?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date