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Alpha2 Agonists, Extended Release Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk: 1-800-454-3730

1. Patient information

Patient name: _____
Patient ID #: _____
Patient DOB: _____
Date of Rx: _____
Patient phone #: _____
Patient email address: _____

2. Physician information

Prescribing physician: _____
Physician address: _____
Physician phone #: _____
Physician fax #: _____
Physician specialty: _____
Physician DEA: _____
Physician NPI #: _____
Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
Nonpreferred (PA Required) □ Intuniv □ Kapvay □ Clonidine ER **Preferred No PA required** □ Guanfacine ER	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for extended-release alpha2 agonists. Payment will be considered for patients when the following is met: 1) The patient has a diagnosis of ADHD and is between 6 and 17 years of age. 2) Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3) previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred nonamphetamine stimulant. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Trial of preferred immediate release product of same chemical entity:
Drug name and dose: _____
Trial dates: _____ failure reason: _____

Trial of preferred amphetamine stimulant:
Drug name and dose: _____
Trial dates: _____ Failure reason: _____

Trial of preferred nonamphetamine stimulant:
Drug name and dose:_____

Trial dates:_____ Failure reason:_____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.