

MERCY

Health Plans

A Coventry Health Care Plan

Amphetamine Prior Authorization Request Form

(Use for Adderall, Adderall XR, Dexedrine, Dextrostat, Desoxyn, and their generics)

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-647-2240. For additional information call 314-214-8282 or 800-647-2240.

Patient Name: _____

Today's Date: ____/____/____

Patient Pharmacy ID: _____

Date of Birth: ____/____/____

(located on bottom right of insurance card)

Requesting Physician: _____

Specialty: _____

(Please print)

Office Contact Person: _____

Phone #: (____)____-____ext____

Office Address: _____

Medication/dose Requested: _____

Fax #: ____ (____) ____ - _____

Expected Duration of Therapy: _____

ICD-9 _____

- | | | |
|---|-----|----|
| 1. Is the patient older than 3 years of age? | YES | NO |
| 2. Is the patient younger than 19 years of age? | YES | NO |
| 3. Does the patient have a diagnosis of ADHD? | YES | NO |
| 4. Does the patient have a diagnosis of narcolepsy? | YES | NO |
| 5. Has the diagnosis been confirmed by sleep studies? | YES | NO |
| 6. Has the patient been evaluated for other causes of excessive daytime sleepiness (such as insufficient sleep syndrome, upper airway resistance syndrome, depression)? | YES | NO |
| 7. Does the patient have ADHD symptoms in more than one setting (school/work and home)? | YES | NO |
| 8. Has the patient had symptoms for longer than six months? | YES | NO |
| 9. Have other primary psychiatric disorders and/or secondary environmental factors been considered? | YES | NO |
| 10. Are the ADHD symptoms causing clinically significant impairment in social, academic, or occupational functioning? | YES | NO |
| 11. Will the patient be regularly monitored for adverse events such as weight loss, decreased growth velocity (for children), and long-term usefulness? | YES | NO |

Physician's Signature: _____

Date: ____/____/____

For Mercy Health Plans use only:

Approved Length of Approval _____

Denied Reason for Denial _____

Reviewer's Signature: _____ Date Reviewed: ____/____/____

Override Entered in Caremark CCMS for _____ - _____ by _____

Office Notified on _____; at _____ am/pm; by _____ spoke to _____