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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

**Patient Name:** \_\_\_\_\_ **Date:** 8/9/2024  
**Patient ID:** \_\_\_\_\_ **Patient Date Of Birth:** \_\_\_\_\_  
**Patient Group No:** \_\_\_\_\_ **Patient Phone:** \_\_\_\_\_ **Physician Name:** \_\_\_\_\_  
**NPI#:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_

**Physician Office Address:** \_\_\_\_\_

**Drug Name (specify drug)** \_\_\_\_\_  
**Quantity:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Strength:** \_\_\_\_\_

**Route of Administration:** \_\_\_\_\_ **Expected Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

**Please check the appropriate answer for each applicable question.**

- |  |   |                          |   |                          |
|--|---|--------------------------|---|--------------------------|
| 1. Does the patient have a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)?   | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. Is this request for continuation of therapy?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. Has the patient achieved or maintained improvement in their signs and symptoms of ADHD/ADD (Attention-Deficit/Hyperactivity Disorder or Attention Deficit Disorder) from baseline?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. Has the patient's need for continued therapy been assessed within the previous year?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. Has the diagnosis been appropriately documented (e.g., evaluated by a complete clinical assessment, using DSM-5, standardized rating scales, interviews/questionnaires)?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. Is the patient 6 years of age or older?   | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. Has the patient experienced an inadequate treatment response to an amphetamine product (e.g., amphetamine, amphetamine-dextroamphetamine, dextroamphetamine, methamphetamine, lisdexamfetamine) OR a methylphenidate product (e.g., methylphenidate, dexamethylphenidate)?          | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 8. Has the patient experienced an intolerance to an amphetamine product (e.g., amphetamine, amphetamine-dextroamphetamine, dextroamphetamine, methamphetamine, lisdexamfetamine) OR a methylphenidate product (e.g., methylphenidate, dexamethylphenidate)?                            | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 9. Does the patient have a contraindication that would prohibit a trial of an amphetamine product (e.g., amphetamine, amphetamine-dextroamphetamine, dextroamphetamine, methamphetamine, lisdexamfetamine) AND a methylphenidate product (e.g., methylphenidate, dexamethylphenidate)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

**Prescriber (Or Authorized) Signature and Date**

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