PA Request Criteria

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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 Address: _____ **Physician Office Telephone:**

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** ☐	**N** ☐
2.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
4.	Has the patient's need for continued therapy been assessed within the previous year?	**Y** ☐	**N** ☐
5.	Has the diagnosis been appropriately documented (e.g., evaluated by a complete clinical assessment, using DSM-5, standardized rating scales, interviews/questionnaires)?	**Y** ☐	**N** ☐
6.	Is the patient 6 years of age or older?	**Y** ☐	**N** ☐
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, dexmethylphenidate)?	**Y** ☐	**N** ☐
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, dexmethylphenidate)?	**Y** ☐	**N** ☐
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, dexmethylphenidate)?	**Y** ☐	**N** ☐

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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