PA Request Criteria

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CAREFIRST - MD EXCHANGE 5T

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 11/28/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)
Guanfacine ER

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. Is the requested drug being used to treat one of the following conditions: A) pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, B) pediatric acute onset neuropsychiatric syndrome? **Y** ☐ **N** ☐
2. Does the patient have the diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? **Y** ☐ **N** ☐
3. 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** ☐
4. 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** ☐
5. 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

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark