



**BlueCross
BlueShield**

Federal Employee Program

**DAYTRANA
PRIOR APPROVAL REQUEST**

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn: Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			Physician Signature:		
PHYSICIAN COMPLETES						

Daytrana (methylphenidate)

NOTE: Form must be completed in its **entirety** for processing

Please select strength(s) and indicate the quantity used per day:

<input type="checkbox"/> 10mg	qty _____	patch(es) per day	<input type="checkbox"/> 20mg	qty _____	patch(es) per day
<input type="checkbox"/> 15mg	qty _____	patch(es) per day	<input type="checkbox"/> 30mg	qty _____	patch(es) per day

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ☐ Brand ☐ Generic

1. What is the patient's total daily dose (mg/day) of Daytrana? _____ mg/day

2. Is this a request for:

☐ Initiation of methylphenidate therapy ☐ Change of dose (replacement of current methylphenidate therapy)
☐ Renewal of therapy ☐ Additional dose (in addition to current methylphenidate therapy)

3. What is the patient's diagnosis?

☐ Attention deficit disorder (ADD) ☐ Attention deficit hyperactivity disorder (ADHD) ☐ Narcolepsy
☐ Depressive disorder

a. Will Daytrana be used in combination with antidepressants? ☐ Yes ☐ No*

***If NO**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to antidepressants? ☐ Yes ☐ No

☐ None of the above

4. Will Daytrana be used in combination with Azstarys? ☐ Yes ☐ No

5. Will Daytrana be used in combination with any of the following: Adhansia XR, Aptensio XR, Concerta, Jornay PM, Metadate CD, Methylin chewable tablets, Methylphenidate, Methylphenidate ER, Methylphenidate oral solution, QuilliChew ER, Quillivant XR oral suspension, Relexxii, or Ritalin LA? ☐ Yes* ☐ No

***If YES**, please select drug and specify the quantity for each strength:

☐ Adhansia XR (please specify): _____
☐ Aptensio XR (please specify): _____
☐ Concerta (please specify): _____
☐ Jornay PM (please specify): _____
☐ Metadate CD (please specify): _____
☐ Methylin chewable tablets (please specify): _____
☐ Methylphenidate (please specify): _____
☐ Methylphenidate ER (please specify): _____
☐ Methylphenidate oral solution (please specify): _____
☐ QuilliChew ER (please specify): _____
☐ Quillivant XR oral suspension (please specify): _____
☐ Relexxii (please specify): _____
☐ Ritalin LA (please specify): _____
☐ Combination/other (please specify): _____



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA .
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

**faster...
easier...
better...**

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

CVS/caremark 