

METHYLPHENIDATE 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

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:			Provi	Provider Name:			
Patient Name:			Speci	Specialty: N		NPI:	
Date of Birth:	Sex: □Male □Female		nale Office	Office Phone:		Office Fax:	
Street Address:			Office	e Street Address:			
City:	State:	Zip:	City:		State:	Zip:	
Patient ID:			Physi	cian Signature:			
R I		1 1					
		PHYS	ICIAN COM	PLETES			
	NOTE: F	orm must be	completed in it	s entirety for processing			
lease select drug, strength(s			-	- -			
Fablets:	<u>,, and mulcate</u>	the quantit	y being preser	Capsules:			
☐ I ablets. ☐ 5mg: Ritalin/Methylin		atv	per day	<u>Capsules</u> . □Adhansia XR 25m	a atv	per da	
110mg: Ritalin/Methylin			per day	□Adhansia XR 35m	9	per da	
320mg: Ritalin/Methylin			per day	□Adhansia XR 45m	0	per da	
JER 10mg: Methylin			per day	□Adhansia XR 55m	_	per da	
□ER/SR 20mg: Ritalin/Metadate /Methylin			per day	□Adhansia XR 70m		per da	
	······································	17	F J	□Adhansia XR 85m		per da	
□Concerta ER 18mg		qty	per day				
□Concerta ER 27mg			per day	□Aptensio XR 10mg	qty_	per da	
□Concerta ER 36mg			per day	□Aptensio XR 15mg		per da	
□Concerta ER 54mg		qty	per day	□Aptensio XR 20mg		per da	
				☐Aptensio XR 30mg		per da	
□Relexxii 18mg			per day	□Aptensio XR 40mg		per da	
□Relexxii 27mg			per day	□Aptensio XR 50mg		per da	
□Relexxii 36mg		qty	per day	□Aptensio XR 60mg	qty_	per da	
□Relexxii 45mg		qty	per day				
□Relexxii 54mg		qty	per day	□Jornay PM 20mg	qty_	per da	
□Relexxii 63mg		qty	per day	□Jornay PM 40mg	qty_	per da	
□Relexxii 72mg		qty	per day	□Jornay PM 60mg	qty_	per da	
J			-	□Jornay PM 80mg		per da	
Chewable tablets:				□Jornay PM 100mg		per da	
☐Methylin 2.5mg		qty	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

☐Methylin 5mg

Solutions:

☐Methylin 10mg

□Quillichew ER 20mg

□Quillichew ER 30mg

□Quillichew ER 40mg

□Methylin 5mg/5ml

□Methylin 10mg/5ml

□Quillivant XR 5mg/ml

1. What is the patient's total daily dose (mg/day) of **ALL** Methylphenidates added together for the patient's current regimen? *Answer below:*______ mg per day

qty _____ per day

qty _____ per day

qty _____ per day
qty ____ per day
qty ____ per day
qty ____ per day

qty _____ per day qty _____ per day

qty _____ per day

☐Metadate CD 10mg

☐Metadate CD 20mg

☐Metadate CD 30mg

☐Metadate CD 40mg

☐Metadate CD 50mg ☐Metadate CD 60mg

□Ritalin LA 10mg

□Ritalin LA 20mg

□Ritalin LA 30mg

□Ritalin LA 40mg

□Ritalin LA 60mg

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

PAGE 1 of 2

__ per day

__ per day

_ per day

qty _____ per day

qty _____ per day qty ____ per day qty ____ per day

qty _____ per day ____ per day

qty _____ per day

qty _____

qty _____

qty _____

qty _____



BlueShield. METHYLPHENIDATE Federal Employee Program. 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.

PAGE 2 – PHYSICIAN COMPLETES				
Patient Name:	DOB:	Patient ID: R		
 What is the patient's diagnosis? □Attention deficit disorder (ADD))			
☐Attention deficit hyperactivity d	isorder (ADHD)			
□Depressive disorder				
a. Will the medication be used	l in combination with antidepre	essants? □Yes □No*		
* $If NO$, does the patient I antidepressants? \square Yes	nave an intolerance or contraine No	dication or have they had an inadequate treatment response to		
□Narcolepsy				
☐None of the above				
3. Will this medication be used in cor	mbination with Azstarys? □Y	es 🔲 No		
PM, Metadate CD, Methylin chew ER, Quillivant XR oral suspension	able tablets, Methylphenidate, n, Relexxii, or Ritalin LA?	f the following: Adhansia XR, Aptensio XR, Concerta ER, Jorna Methylphenidate ER, Methylphenidate oral solution, QuilliCheves* \square No uantity needed PER DAY for each strength:		
□Adhansia XR (please specify):				
☐ Aptensio XR (please specify): _				
☐Concerta ER (please specify): _				
☐Jornay PM (please specify):				
☐Metadate CD (please specify):				
☐Methylin chewable tablets (pla	ease specify):			
☐Methylphenidate (please specif	ÿ):			
☐Methylphenidate ER (please sp	vecify):			
☐Methylphenidate oral solution	(please specify):			
☐QuilliChew ER (please specify)	ı:			
☐Quillivant XR oral suspension	(please specify):			
☐Relexxii (please specify):				
□Ritalin LA (please specify):				
☐Multiple medications (please s				

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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. Please only fax the completed form once as duplicate submissions may delay processing times.

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easier...
better...

CVS/caremark

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