



**BlueCross
BlueShield**

Federal Employee Program

METHYLPHENIDATE PRIOR APPROVAL REQUEST

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.

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

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 				Physician Signature:		
PHYSICIAN COMPLETES						

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

Please select drug, strength(s), and indicate the quantity being prescribed for each per day:

Tablets:		Capsules:	
<input type="checkbox"/> 5mg: Ritalin/Methylin	qty _____ per day	<input type="checkbox"/> Adhansia XR 25mg	qty _____ per day
<input type="checkbox"/> 10mg: Ritalin/Methylin	qty _____ per day	<input type="checkbox"/> Adhansia XR 35mg	qty _____ per day
<input type="checkbox"/> 20mg: Ritalin/Methylin	qty _____ per day	<input type="checkbox"/> Adhansia XR 45mg	qty _____ per day
<input type="checkbox"/> ER 10mg: Methylin	qty _____ per day	<input type="checkbox"/> Adhansia XR 55mg	qty _____ per day
<input type="checkbox"/> ER/SR 20mg: Ritalin/Metadate /Methylin	qty _____ per day	<input type="checkbox"/> Adhansia XR 70mg	qty _____ per day
<input type="checkbox"/> Concerta ER 18mg	qty _____ per day	<input type="checkbox"/> Adhansia XR 85mg	qty _____ per day
<input type="checkbox"/> Concerta ER 27mg	qty _____ per day	<input type="checkbox"/> Aptensio XR 10mg	qty _____ per day
<input type="checkbox"/> Concerta ER 36mg	qty _____ per day	<input type="checkbox"/> Aptensio XR 15mg	qty _____ per day
<input type="checkbox"/> Concerta ER 54mg	qty _____ per day	<input type="checkbox"/> Aptensio XR 20mg	qty _____ per day
<input type="checkbox"/> Relexxii 18mg	qty _____ per day	<input type="checkbox"/> Aptensio XR 30mg	qty _____ per day
<input type="checkbox"/> Relexxii 27mg	qty _____ per day	<input type="checkbox"/> Aptensio XR 40mg	qty _____ per day
<input type="checkbox"/> Relexxii 36mg	qty _____ per day	<input type="checkbox"/> Aptensio XR 50mg	qty _____ per day
<input type="checkbox"/> Relexxii 45mg	qty _____ per day	<input type="checkbox"/> Aptensio XR 60mg	qty _____ per day
<input type="checkbox"/> Relexxii 54mg	qty _____ per day	<input type="checkbox"/> Jornay PM 20mg	qty _____ per day
<input type="checkbox"/> Relexxii 63mg	qty _____ per day	<input type="checkbox"/> Jornay PM 40mg	qty _____ per day
<input type="checkbox"/> Relexxii 72mg	qty _____ per day	<input type="checkbox"/> Jornay PM 60mg	qty _____ per day
<input type="checkbox"/> Relexxii 72mg	qty _____ per day	<input type="checkbox"/> Jornay PM 80mg	qty _____ per day
<input type="checkbox"/> Relexxii 72mg	qty _____ per day	<input type="checkbox"/> Jornay PM 100mg	qty _____ per day
Chewable tablets:		<input type="checkbox"/> Metadate CD 10mg	
<input type="checkbox"/> Methylin 2.5mg	qty _____ per day	<input type="checkbox"/> Metadate CD 20mg	qty _____ per day
<input type="checkbox"/> Methylin 5mg	qty _____ per day	<input type="checkbox"/> Metadate CD 30mg	qty _____ per day
<input type="checkbox"/> Methylin 10mg	qty _____ per day	<input type="checkbox"/> Metadate CD 40mg	qty _____ per day
<input type="checkbox"/> Quillichew ER 20mg	qty _____ per day	<input type="checkbox"/> Metadate CD 50mg	qty _____ per day
<input type="checkbox"/> Quillichew ER 30mg	qty _____ per day	<input type="checkbox"/> Metadate CD 60mg	qty _____ per day
<input type="checkbox"/> Quillichew ER 40mg	qty _____ per day	<input type="checkbox"/> Ritalin LA 10mg	qty _____ per day
Solutions:		<input type="checkbox"/> Ritalin LA 20mg	qty _____ per day
<input type="checkbox"/> Methylin 5mg/5ml	qty _____ per day	<input type="checkbox"/> Ritalin LA 30mg	qty _____ per day
<input type="checkbox"/> Methylin 10mg/5ml	qty _____ per day	<input type="checkbox"/> Ritalin LA 40mg	qty _____ per day
<input type="checkbox"/> Quillivant XR 5mg/ml	qty _____ per day	<input type="checkbox"/> Ritalin LA 60mg	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

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

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

PAGE 1 of 2



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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

2. What is the patient's diagnosis?

☐ Attention deficit disorder (ADD)

☐ Attention deficit hyperactivity disorder (ADHD)

☐ Depressive disorder

a. Will the medication 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

☐ Narcolepsy

☐ None of the above

3. Will this medication be used in combination with Azstarys? ☐ Yes ☐ No

4. Will the requested medication be used in combination with any of the following: Adhansia XR, Aptensio XR, Concerta ER, 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 each strength and the quantity 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 (*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*): _____

☐ Multiple medications (*please specify*): _____

PAGE 2 of 2



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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...	Introducing ePA! Online Prior Authorizations in minutes through Caremark.com/ePA. Sign up today!
easier...	
better...	
CVS/caremark 	