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: ❑Male ❑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:

- ❒**5mg: Ritalin/Methylin** qty _____ per day
- ❒**10mg: Ritalin/Methylin** qty _____ per day
- ❒**20mg: Ritalin/Methylin** qty _____ per day
- ❒**ER 10mg: Methylin** qty _____ per day
- ❒**ER/SR 20mg: Ritalin/Metadate /Methylin** qty _____ per day

- ❒**Concerta ER 18mg** qty _____ per day
- ❒**Concerta ER 27mg** qty _____ per day
- ❒**Concerta ER 36mg** qty _____ per day
- ❒**Concerta ER 54mg** qty _____ per day

- ❑**Relexxii 18mg** qty _____ per day
- ❑**Relexxii 27mg** qty _____ per day
- ❑**Relexxii 36mg** qty _____ per day
- ❑**Relexxii 45mg** qty _____ per day
- ❑**Relexxii 54mg** qty _____ per day
- ❑**Relexxii 63mg** qty _____ per day
- ❑**Relexxii 72mg** qty _____ per day

Chewable tablets:

- ❒**Methylin 2.5mg** qty _____ per day
- ❒**Methylin 5mg** qty _____ per day
- ❒**Methylin 10mg** qty _____ per day
- ❒**Quillichew ER 20mg** qty _____ per day
- ❒**Quillichew ER 30mg** qty _____ per day
- ❒**Quillichew ER 40mg** qty _____ per day

Solutions:

- ❒**Methylin 5mg/5ml** qty _____ per day
- ❒**Methylin 10mg/5ml** qty _____ per day
- ❒**Quillivant XR 5mg/ml** qty _____ per day

Capsules:

- ❒**Adhansia XR 25mg** qty _____ per day
- ❒**Adhansia XR 35mg** qty _____ per day
- ❒**Adhansia XR 45mg** qty _____ per day
- ❒**Adhansia XR 55mg** qty _____ per day
- ❒**Adhansia XR 70mg** qty _____ per day
- ❒**Adhansia XR 85mg** qty _____ per day

- ❒**Aptensio XR 10mg** qty _____ per day
- ❒**Aptensio XR 15mg** qty _____ per day
- ❒**Aptensio XR 20mg** qty _____ per day
- ❒**Aptensio XR 30mg** qty _____ per day
- ❒**Aptensio XR 40mg** qty _____ per day
- ❒**Aptensio XR 50mg** qty _____ per day
- ❒**Aptensio XR 60mg** qty _____ per day

- ❒**Jornay PM 20mg** qty _____ per day
- ❒**Jornay PM 40mg** qty _____ per day
- ❒**Jornay PM 60mg** qty _____ per day
- ❒**Jornay PM 80mg** qty _____ per day
- ❒**Jornay PM 100mg** qty _____ per day

- ❒**Metadate CD 10mg** qty _____ per day
- ❒**Metadate CD 20mg** qty _____ per day
- ❒**Metadate CD 30mg** qty _____ per day
- ❒**Metadate CD 40mg** qty _____ per day
- ❒**Metadate CD 50mg** qty _____ per day
- ❒**Metadate CD 60mg** qty _____ per day

- ❒**Ritalin LA 10mg** qty _____ per day
- ❒**Ritalin LA 20mg** qty _____ per day
- ❒**Ritalin LA 30mg** qty _____ per day
- ❒**Ritalin LA 40mg** qty _____ per day
- ❒**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

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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)***: _____

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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.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Methylphenidate – FEP MD Fax Form Revised 12/15/2023