



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Desoxyn (Medicare Prior Authorization)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Desoxyn (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)
Desoxyn (methamphetamine)

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|---|
| 1. Is the patient 3 years old or older? | Y | N |
| 2. Does the patient have a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD)?
[If the answer to this question is yes, skip to question 6.] | Y | N |
| 3. Is the medication being prescribed Vyvanse (lisdexamfetamine)?
[If the answer to this question is yes, no further questions are required.] | Y | N |
| 4. Does the patient have the diagnosis of narcolepsy?
[If the answer to this question is no, no further questions are required.] | Y | N |
| 5. Has the diagnosis been confirmed by sleep studies? | Y | N |
| 6. Will the patient be on a monoamine oxidase inhibitor (MAOI) drug while taking this therapy or has the patient been on an MAOI drug in the previous 14 days?
[MAOI drugs include: phenelzine (Nardil), tranylcypromine (Parnate), isocarboxazid (Marplan), and selegiline (Eldepryl, Emsam)] | Y | N |
| 7. Will the patient be regularly monitored for adverse events, including weight loss and decreased growth velocity for children, increased heart rate and blood pressure, the appearance or worsening of aggressive behavior or hostility, sleep disturbances, and long-term | Y | N |



**Arkansas
BlueCross BlueShield**

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usefulness of the drug?

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date