



Prior Authorization Form

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

**Drug Name (select from list of drugs shown)**  
Dextrostat (dextroamphetamine sulfate tablet)

**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)?<br>[If the answer to this question is yes, skip to question 6.]  | Y | N |
| 3. Is the medication being prescribed Vyvanse (lisdexamfetamine) or Desoxyn (methamphetamine)?<br>[If the answer to this question is yes, no further questions are required.]   | Y | N |
| 4. Does the patient have the diagnosis of narcolepsy?<br>[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?<br>[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   | Y | N |



**Arkansas  
BlueCross BlueShield**

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worsening of aggressive behavior or hostility, sleep disturbances,  
and long-term usefulness of the drug?

**Comments:**

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

**Prescriber (Or Authorized) Signature and Date**

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