



Prior Authorization Form

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

Drug Name(specify drug)

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 6 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 a Focalin product (dexmethylphenidate)? [If the answer to this question is yes, no further questions are required.] | Y | N |
| 4. Does the patient have a 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 | 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:

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

Prescriber (Or Authorized) Signature and Date
