



ADHD Agents Quantity Limit Prior Authorization Form

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested _____ **Quantity** _____ **units per** _____ **Days**
(one drug per form only)

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Office Contact: _____
 Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

*****MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE*****

1. **PROVIDER SPECIALTY** (specify all) _____
2. **DIAGNOSIS FOR DRUG REQUESTED** (specify all) _____
3. **MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	Duration of therapy (include dates)	Currently prescribed
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please add or attach any other supporting medical information and/or clinical trials that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL