



Prior Authorization Form

Daytrana® (Methylphenidate transdermal system)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [] Daytrana®
Date: _____ Patient ID#: _____ DOB: _____
Patient Name: _____ Provider NPI: _____
Prescribing Physician: _____ Office Contact: _____
Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

- [] Attention deficit hyperactivity disorder (ADHD)
[] Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes blank rows for data entry.

3. PATIENT HISTORY

- a. Has the patient tried and failed or has a contraindication/intolerance allergy to Adderall or Adderall XR? [] Yes [] No
b. Has the patient tried and failed or has a contraindication/intolerance allergy to a methylphenidate containing product? [] Yes [] No
c. Has the patient tried and failed or has a contraindication/intolerance allergy to Strattera? [] Yes [] No
d. Has the patient tried and failed or has a contraindication/intolerance allergy to a dextroamphetamine containing product? [] Yes [] No
e. Has the patient tried and failed or has a contraindication/intolerance allergy to Desoxyn? [] Yes [] No
f. Has the patient tried and failed or has a contraindication/intolerance/allergy to dexmethylphenidate containing product? [] Yes [] No

Please add any other supporting medical information that may be useful in the decision-making process:

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

Internal use only
Document # _____ Coverage effective date / / _____
Processor Initials _____ Date _____
M F Rx coverage Y N STANDARD - SELECT LOB _____
Previous Auth Y N Approved Reviewer Initials _____ Date _____