



Prior Authorization Form

VYVANSE® /INTUNIV®/DAYTRANA®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

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

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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 three rows of blank lines for entry.

3. PATIENT HISTORY

a. Has the patient tried and failed any of the following?

- Methylphenidate containing product [] Yes [] No [] N/A
Mixed amphetamine salts containing product (Adderall or Adderall XR) [] Yes [] No [] N/A
Strattera [] Yes [] No [] N/A
Dextroamphetamine containing product [] Yes [] No [] N/A
Desoxyn [] Yes [] No [] N/A
Dexmethylphenidate containing product [] Yes [] No [] N/A

b. Is there a history of or potential for drug abuse among the patient or the member of the household?

- [] Yes [] No [] N/A

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

Three horizontal lines for providing additional medical information.

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