



Prior Authorization Form

VYVANSE /INTUNIV/DAYTRANA/KAPVAY ER

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [ ] Intuniv [ ] Vyvanse [ ] Daytrana [ ] Kapvay ER
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.