FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Strattera® (atomoxetine) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Quantity limit requests:

What is the quantity requested per DAY? _____

Is the prescription written by or in consultation with a mental health specialist? ❑ **Yes** ❑ **No**

Will peer-reviewed medical literature or national compendia supporting the use of higher doses be provided?* ❑ **Yes** ❑ **No**

**Please note: Submission of information requested above is required for quantity limit requests for this drug.*

Have the maximum doses specified under the quantity restriction been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition? ❑ **Yes** ❑ **No**

Have lower doses been tried? ❑ **Yes** ❑ **No**

If "no" to the above question, is there clinical support (i.e., clinical literature, patient attributes, or characteristics of the drug) that the number of doses available under the quantity restriction will be ineffective in the treatment of the patient's disease or medical condition?* ❑ **Yes** ❑ **No**

**Please note: Submission of information requested above is required for quantity limit requests for this drug.*

What is the reason for exceeding the plan limitations?

❑ Titration

❑ Loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.