



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: |
| <input type="checkbox"/> Check if generic substitution is acceptable | Directions for Use: | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | |

| Clinical Information (required) |
|---|
| <p>Select the diagnosis below:</p> <input type="checkbox"/> Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ |
| <p>Quantity limit requests:</p> <p>What is the quantity requested per DAY? _____</p> <p>Is the prescription written by or in consultation with a mental health specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will peer-reviewed medical literature or national compendia supporting the use of higher doses be provided?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>*Please note: Submission of information requested above is required for quantity limit requests for this drug.</i></p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have lower doses been tried? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>*Please note: Submission of information requested above is required for quantity limit requests for this drug.</i></p> <p>What is the reason for exceeding the plan limitations?</p> <input type="checkbox"/> Titration <input type="checkbox"/> Loading dose purposes <input type="checkbox"/> 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) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> 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.

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