1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Adderall XR® (amphetamine-dextroamphetamine extended-release [ER])
Prior Authorization Request Form (Page 1 of 2)

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Attention deficit disorder (ADD)
- ❑ Attention deficit hyperactivity disorder (ADHD)
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

For brand Adderall XR, select the medications the patient has a failure, contraindication, or intolerance to:

❑ Adzenys XR-ODT	❑ Dextroamphetamine ER	❑ Methylphenidate ER (10mg, 20mg tablets)
❑ Amphetamine-dextroamphetamine	❑ Evekeo	❑ Methylphenidate ER (generic Concerta)
❑ Amphetamine-dextroamphetamine ER	❑ Focalin XR	❑ Methylphenidate ER (generic Ritalin LA)
❑ Aptensio XR	❑ Guanfacine ER	❑ Methylphenidate solution
❑ Clonidine ER	❑ Metadate ER	❑ Quillichew ER
❑ Daytrana	❑ Methamphetamine	❑ Quillivant XR
❑ Dexmethylphenidate	❑ Methylphenidate (generic Ritalin)	❑ Ritalin LA
❑ Dexmethylphenidate ER	❑ Methylphenidate chewable tablet	❑ Vyvanse
❑ Dextroamphetamine	❑ Methylphenidate CD (generic Metadate CD)	❑ Zenzedi

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
- ❑ Titration or 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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ 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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

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Prior Authorization Request Form (Page 2 of 2)

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	