Prior Authorization Form

Daytrana® (Methylphenidate transdermal system)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: ☐ **Daytrana®**

Date: ______________________ Patient ID#: ______________ DOB:__________

Patient Name: ______________________ Provider NPI: ______________________

Prescribing Physician: ______________________ Office Contact: ______________________

Office Fax #: ______________________ Office Phone: ______________________

ONLY COMPLETED REQUESTS WILL BE REVIEWED

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."

Drug Name	Date	Duration

3. PATIENT HISTORY

a. Has the patient tried and failed or has a contraindication/intolerance allergy to Adderall or Adderall XR? ☐ Yes ☐ No

b. Has the patient tried and failed or has a contraindication/intolerance allergy to a methylphenidate containing product? ☐ Yes ☐ No

c. Has the patient tried and failed or has a contraindication/intolerance allergy to Strattera? ☐ Yes ☐ No

d. Has the patient tried and failed or has a contraindication/intolerance allergy to a dextroamphetamine containing product? ☐ Yes ☐ No

e. Has the patient tried and failed or has a contraindication/intolerance allergy to Desoxyn? ☐ Yes ☐ No

f. Has the patient tried and failed or has a contraindication/intolerance/allergy to dexmethylphenidate containing product? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

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

Internal use only | **Coverage effective date** / /

Document #______________________ Processor Initials__________ Date________________

M F Rx coverage Y N STANDARD - SELECT LOB________________

Previous Auth Y N **Approved** **Reviewer Initials**__________ Date__________

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