CAREFIRST - DC EXCHANGE 5T
ADHD Agents Post Limit (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of ADHD Agents Post Limit (HMF).

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

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_____

Please check the appropriate answer for each applicable question.

1. Is this request for one of the following: A) Adhansia XR, B) Aptensio XR 60 mg, C) Daytrana, D) Desoxyn, E) Dyanavel XR, F) Focalin XR 20 mg, 30 mg, 35 mg, or 40 mg, G) Jornay PM, H) methylphenidate CD 60 mg, I) Methylphenidate Osmotic Extended-Release 72 mg, J) Mydayis 25 mg, 37.5 mg, or 50 mg, K) Ritalin LA 60 mg, L) Strattera, M) Vyvanse? **Y** ☐ **N** ☐
2. Does the patient have a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? **Y** ☐ **N** ☐
3. Has the diagnosis been appropriately documented (i.e., evaluated by a complete clinical assessment, using DSM-5, standardized rating scales, interviews/questionnaires)? **Y** ☐ **N** ☐
4. Which drug is being requested (applies to brand or generic)?
   - Adderall (amphetamine mixture) (if checked, go to 5) ☐
   - Adderall XR (amphetamine extended-release mixture) (if checked, go to 5) ☐
   - Adzenys ER (amphetamine extended-release oral suspension) (if checked, go to 6) ☐
   - Adzenys XR-ODT (amphetamine extended-release orally disintegrating tablets) (if checked, go to 6) ☐
   - Aptensio XR (methylphenidate extended-release) (if checked, go to 7) ☐
   - Concerta (methylphenidate extended-release) (if checked, go to 8) ☐
   - Cotempla XR (methylphenidate extended-release orally disintegrating tablet) (if checked, go to 9) ☐

Dexedrine Spansule (dextroamphetamine sustained-release) (if checked, go to 10) ☐

dextroamphetamine (if checked, go to 10) ☐

Evekeo (amphetamine sulfate) (if checked, go to 11) ☐

Evekeo ODT (amphetamine sulfate orally disintegrating tablet) (if checked, go to 11) ☐

Focalin (dexmethylphenidate) (if checked, go to 12) ☐

Focalin XR (dexmethylphenidate extended-release) (if checked, go to 12) ☐

methylphenidate CD (methylphenidate extended-release) (if checked, go to 13) ☐

Methylphenidate chewable tablet (if checked, go to 14) ☐

methylphenidate tablets (if checked, go to 14) ☐

Methylin (methylphenidate) oral solution (if checked, go to 15) ☐

methylphenidate extended-release (if checked, go to 13) ☐

Mydayis (amphetamine extended-release mixture) (if checked, go to 16) ☐

ProCentra (dextroamphetamine sulfate oral solution) (if checked, go to 17) ☐

QuilliChew ER (methylphenidate extended-release chewable tablets) (if checked, go to 18) ☐

Quillivant XR (methylphenidate hydrochloride extended-release oral suspension) (if checked, go to 19) ☐

Ritalin LA (methylphenidate extended-release) (if checked, go to 13) ☐

Zenzedi (dextroamphetamine) (if checked, go to 10) ☐

[Note: Please check which drug (applies to brand or generic).]

5. Does the patient require use of MORE than any of the following PER MONTH: A) 120 units of Adderall 5 mg, 7.5 mg, 10 mg, 12.5 mg OR Adderall XR 5 mg, 10mg, B) 90 units of Adderall 15 mg, 20 mg, C) 60 units of Adderall 30 mg OR Adderall XR 15 mg, 20 mg, 25 mg, 30 mg? **Y** ☐ **N** ☐

6. Does the patient require use of MORE than any of the following PER MONTH: A) 900 ml of Adzenys ER, B) 120 tablets of Adzenys XR-ODT 3.1 mg, 6.3 mg, 9.4 mg, C) 60 tablets of Adzenys XR-ODT 12.5 mg, 15.7 mg, 18.8 mg? **Y** ☐ **N** ☐

7. Does the patient require use of MORE than any of the following PER MONTH: A) 90 capsules of Aptensio XR 10 mg, 15 mg, 20 mg, 30 mg, B) 60 capsules of Aptensio XR 40 mg, 50 mg? **Y** ☐ **N** ☐

8. Does the patient require use of MORE than any of the following PER MONTH: A) 90 tablets of Concerta 18 mg, 27 mg, 36 mg, B) 60 tablets of Concerta 54 mg? **Y** ☐ **N** ☐

9. Does the patient require use of MORE than any of the following PER MONTH: A) 120 tablets of Cotempla XR 8.6 mg, 17.3 mg, B) 90 tablets of Cotempla XR 25.9 mg? **Y** ☐ **N** ☐

10. Does the patient require use of MORE than any of the following PER MONTH: A) 180 tablets of dextroamphetamine 5 mg, 10 mg OR Zenzedi 2.5 mg, 5 mg, 7.5 mg, 10 mg, B) 150 capsules of Dexedrine Spansule 5 mg, 10 mg, C) 120 units of Dexedrine Spansule 15 mg OR Zenzedi 15 mg, D) 90 tablets of Zenzedi 20 mg, E) 60 tablets of Zenzedi 30 mg? **Y** ☐ **N** ☐

11. Does the patient require use of MORE than any of the following PER MONTH: A) 180 tablets of Evekeo / Evekeo ODT 5 mg or 10 mg, B) 90 tablets of Evekeo ODT 15 mg or 20 mg? **Y** ☐ **N** ☐

12. Does the patient require use of MORE than any of the following PER MONTH: A) 150 tablets of Focalin 2.5 mg, 5 mg, 10 mg, B) 90 capsules of Focalin XR 5 mg, 10 mg, 15 mg, C) 60 capsules of Focalin XR 25 mg? **Y** ☐ **N** ☐

13. Does the patient require use of MORE than any of the following PER MONTH: A) 150 units of methylphenidate ER 10 mg, 20 mg OR Ritalin LA 10 mg, 20 mg, B) 90 capsules of methylphenidate CD 10 mg, 20 mg, 30 mg OR Ritalin LA 30 mg, C) 60 capsules of methylphenidate CD 40 mg, 50 mg OR Ritalin LA 40 mg? **Y** ☐ **N** ☐

14. Does the patient require use of MORE than any of the following PER MONTH: A) 300 tablets of methylphenidate chewable 2.5 mg, 5 mg, 10 mg, B) 210 tablets of methylphenidate 5 mg, 10 mg, C) 150 tablets of methylphenidate 20 mg? **Y** ☐ **N** ☐

15. Does the patient require use of MORE than any of the following PER MONTH: A) 3,000 ml of Methylin (methylphenidate) oral solution 5 mg/5 ml, B) 1,500 ml of Methylin (methylphenidate) oral solution 10 mg/5 ml? **Y** ☐ **N** ☐

16. Does the patient require use of MORE than 90 capsules PER MONTH of Mydayis 12.5 mg? **Y** ☐ **N** ☐

17. Does the patient require use of MORE than 1,800 ml PER MONTH of ProCentra oral solution 5 mg/5 ml? **Y** ☐ **N** ☐

18. Does the patient require use of MORE than any of the following PER MONTH: A) 150 tablets of QuilliChew ER 20 mg, B) 90 tablets of QuilliChew ER 30 mg, C) 60 tablets of QuilliChew ER 40 mg? **Y** ☐ **N** ☐

19. Does the patient require use of MORE than 600 ml PER MONTH of Quillivant XR oral suspension 25 mg/5 ml (5 mg/1 ml)? **Y** ☐ **N** ☐

20. Does the patient have a diagnosis of narcolepsy confirmed by a sleep study? **Y** ☐ **N** ☐

21. Is this request for amphetamine extended-release (Adzenys ER, Adzenys XR-ODT), amphetamine extended-release mixture (Adderall XR, Mydayis), amphetamine sulfate orally disintegrating tablet (Evekeo ODT), methylphenidate chewable tablet, methylphenidate immediate-release, methylphenidate extended-release (Aptensio XR, Concerta, Cotempla XR-ODT, methylphenidate CD, methylphenidate osmotic extended-release, QuilliChew ER, Quillivant XR, Ritalin LA), dexmethylphenidate (Focalin), or dexmethylphenidate extended-release (Focalin XR)? **Y** ☐ **N** ☐

22. Which drug is being requested (applies to brand or generic)?

- Adderall (amphetamine mixture) (if checked, go to 23) ☐
- Dexedrine Spansule (dextroamphetamine sustained-release) (if checked, go to 24) ☐
- dextroamphetamine (if checked, go to 24) ☐
- Evekeo (amphetamine sulfate) (if checked, go to 25) ☐
- ProCentra (dextroamphetamine sulfate oral solution) (if checked, go to 26) ☐
- Zenzedi (dextroamphetamine) (if checked, go to 24) ☐

[Note: Please check which drug (applies to brand or generic).]

23. Does the patient require use of MORE than any of the following PER MONTH: A) 120 tablets of Adderall 5 mg, 7.5 mg, 10 mg, 12.5 mg, B) 90 tablets of Adderall 15 mg, 20 mg, C) 60 tablets of Adderall 30 mg? **Y** ☐ **N** ☐

24. Does the patient require use of MORE than any of the following PER MONTH: A) 180 tablets of dextroamphetamine 5 mg, 10 mg OR Zenzedi 2.5 mg, 5 mg, 7.5 mg, 10 mg, B) 150 capsules of Dexedrine Spansule 5 mg, 10 mg, C) 120 units of Dexedrine Spansule 15 mg OR Zenzedi 15 mg, D) 90 tablets of Zenzedi 20 mg, E) 60 tablets of Zenzedi 30 mg,? **Y** ☐ **N** ☐

25. Does the patient require use of MORE than 180 tablets PER MONTH of Evekeo 5 mg or 10 mg? **Y** ☐ **N** ☐

26. Does the patient require use of MORE than 1,800 ml PER MONTH of ProCentra oral solution 5 mg/5 ml? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date