

Pharmacy Prior Authorization Form

Last Reviewed: Mar. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Concerta[®] (methylphenidate extended release) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Concerta 18 mg
- Concerta 27 mg
- Concerta 36 mg
- Concerta 54 mg

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization for Concerta requires:

- Diagnosis of ADHD, ADD or Narcolepsy (for patients over the age of 17 years)
- Concerta is limited to once daily dosing

Diagnosis:

- Attention Deficit Disorder with hyperactivity (ADHD)
- Attention Deficit Disorder (ADD)
- Narcolepsy (only indicated for patient's over the age of 17 years)
- Other: _____ Please provide rationale for use:

Patient's age: _____

Patient's weight: _____

Request for once daily dosing:

- Yes
- No – Rationale for use: _____

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX