

Pharmacy Prior Authorization Form

Last Reviewed: Mar. 08

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 S.A.)

Member Name: _____ Member #: _____ - _____

DOB: _____ Sex: _____ Provider Phone: _____

Provider Name: _____ Provider Fax: _____

Provider Office Contact Name: _____ Date: _____

Strength: 18mg 27mg 36mg 54mg

Dose: _____

Priority Health precertification requirements:

PATIENT UNDER 6 YEARS OF AGE

- Diagnosis of hyperactivity
 Diagnosis of Attention Deficit Disorder with hyperactivity (ADHD)

Priority Health precertification requirements:

PATIENTS OVER 17 YEARS OF AGE

- Diagnosis of hyperactivity
 Diagnosis of Attention Deficit Disorder with hyperactivity (ADHD)
 Diagnosis of Narcolepsy

For Internal Use Only

Original Date of Req: _____ Non-Urgent: ___ Urgent: ___ Retro: ___ Method: Phone ___ Fax ___ Ltr ___ Coord. Initial ___
Approved: ___ Denied: ___ Letter Type: Denial ___ 48 hr ___ Off-Label Use ___ Verbal: Y ___ N ___ Inquiry number: _____
Product: HMO ___ PPO ___ ASO ___ POS ___ Caid ___ MICHild ___ Mcare ___ McarePlus ___ McareRX ___ McareValue ___
Formulary (11/0030/R0) ___ Non-Formulary (11/0032/R0) ___
Dte Addt Info Req _____ by: Phone ___ Fax ___ Dte 48/OL Ltr sent: _____ Dte 2nd 48/OL Ltr Sent (Caid only) _____
Date All Info Recvd _____ Date of Decision to Deny: _____ RPh Initials: _____
Notified: _____ of Denial on: _____ by: Ph ___ Fax ___ Provider Fax #: _____