PriorityHealth®

Pharmacy
Prior Authorization Form

Last Reviewed: May 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**

Daytrana® (methylphenidate transdermal patch) ☐ 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:

Daytrana ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 30 mg

Dose: ________________________________ Start date: ____________________

Priority Health Precertification Requirements:

Authorization of Daytrana requires:

- Diagnosis of ADHD
- Age 6-12 years
- Documented therapeutic trial of **both** Ritalin LA and Concerta
- Daytrana is limited to once daily dosing

Diagnosis:

☐ Attention Deficit Disorder with hyperactivity (ADHD)

☐ Other: ______________________________ Please provide rationale for use:

____

Patient's age: ____________________

Documented therapeutic trial with **both** formulary long-acting methylphenidate agents:

	Dose	**Dates**	**Outcome**
☐ Ritalin LA	____________	____________	________________
☐ Concerta	____________	____________	________________

Request is for once daily dosing:

☐ Yes

☐ No – Rationale for use: ____

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Additional Authorization Information:

- Daytrana will not be approved for dose titration. It is recommended that the daily maintenance dose of Daytrana be determined with dose titration of immediate-release methylphenidate.
- The incidence of adverse events with Daytrana (e.g. appetite suppression, weight loss, insomnia) is similar to other methylphenidate products.

Daytrana Dose (delivered over 9 hours)	Dosage Rate (mg/hr)	Methylphenidate Content per Patch (mg)
10	1.1	27.5
15	1.6	41.3
20	2.2	55
30	3.3	82.5

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX