

Pharmacy Prior Authorization Form

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

Methylin[®] (methylphenidate chewable tablets) 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:

- Methylin chewable tablets 2.5 mg
- Methylin chewable tablets 5 mg
- Methylin chewable tablets 10 mg
- Methyline oral solution 5 mg/5 ml

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Methylin requires:

- Diagnosis of attention deficit disorder with hyperactivity or attention deficit disorder
- Age of 6 to 17 years
- Patient must not be able to swallow tablets or capsules

Please Complete the Following Information:

Diagnosis:

- Attention Deficit Disorder with hyperactivity (ADHD)
- Attention Deficit Disorder (ADD)
- Other: _____ Please provide rationale for use: _____

Patient's age: _____

Patient can swallow tablets or capsules:

- Yes – Rationale for use: _____
- No

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX