PriorityHealth

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**

Methylphenidate (all strengths-all dosage forms) ☐ 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: ___________________________________

Dose: _____________________________________ Start date: ____________________

Priority Health Precertification Requirements:

Authorization of methylphenidate requires:

- Diagnosis of attention ADHD, ADD, depression (patients over 17 years old only) or narcolepsy (patients over 17 years old only)

Please Complete the Following Information:

Diagnosis:

- ☐ Attention Deficit Disorder with hyperactivity (ADHD)
- ☐ Attention Deficit Disorder (ADD)
- ☐ Depression (patients over 17 years only)
- ☐ Narcolepsy (patients over 17 years only)
- ☐ Other: ___________________________________ Please provide rationale for use: ____

Patient's age: _______________________

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX