

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

Methylphenidate (all strengths-all dosage forms)

Member Name: _____ Member #: _____ - _____

DOB: _____ Sex: _____ Provider Phone: _____

Provider Name: _____ Provider Fax: _____

Provider Office Contact Name: _____ Date: _____

Drug: _____ Strength: _____

Directions: _____

Priority Health precertification requirement: (one of the following diagnoses must apply)

PATIENTS UNDER 6 YEARS OF AGE (Check one)

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

PATIENTS OVER 17 YEARS OF AGE (Check one)

- Diagnosis of hyperactivity
 Diagnosis of Depression
 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 #: _____