

METHYLIN ER

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the patient 6 years old or older? Y N
2. Does the patient have a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? Y N
[If the answer to this question is yes, skip to question 6.]
3. Is the medication being prescribed Focalin, Focalin XR or dexamethylphenidate? Y N
[If the answer to this question is yes, no further questions are required.]
4. Does the patient have a diagnosis of narcolepsy? Y N
[If the answer to this question is no, no further questions are required.]
5. Has the diagnosis been confirmed by sleep studies? Y N

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6. Will the patient be on a monoamine oxidase inhibitor (MAOI) drug while taking this therapy, or has the patient been on an MAOI drug in the previous days?

- [MAOI drugs include: phenelzine (Nardil), tranylcypromine (Parnate), isocarboxazid (Marplan) and selegiline (Edepryl, Emsam)]

 Y N

7. Has the prescriber weighed/considered the benefits of treatment versus the potential risks of serious cardiovascular events (including sudden death) associated with the use of methylphenidate products?

 Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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