STRATTERA

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

Patient Information	
Name:	**Insurance ID #:**
Group #:	**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
3. 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 14 days? Y N
   - MAOI drugs include: phenelzine (Nardil), tranylcypromine (Pamate), isocarboxazid (Marplan) and selegiline (Eldepryl, Emsam)
4. Will the patient be monitored for adverse events, including liver injury and increase heart rate and blood pressure? Y N
5. Will the patient be monitored closely for suicidal thinking of behavior, clinical worsening and unusual changes in behavior? Y N

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Comments: ____

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

Prescriber's Signature:	**Date:**

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