

# METHYLIN TABLETS

## 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 completed, please fax to Caremark at 1-888-836-0730.**

This fax machine is located 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 1-800-294-5979 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)?  
[If the answer to this question is yes, skip to question 5.]  Y  N
  3. Does the patient have the diagnosis of narcolepsy?  
[If the answer to this question is no, no further questions are required.]  Y  N
  4. Has the diagnosis been confirmed by sleep studies?  Y  N
  5. Will the patient be on a monoamine oxidase (MAOI) drug while taking this therapy or has the patient been on an MOAI drug in the previous 14 days?  Y  N
- [MAOI drugs include: phenelzine (Nardil), tranylcypromine (Parnate), isocarboxazid (Marplan), and selegiline (Eldepryl, Emsam)]

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6. Will the patient be regularly monitored for adverse events, including weight loss and decreased growth velocity for children, increased heart rate and blood pressure, the appearance or worsening of aggressive behavior or hostility, sleep disturbances, and long-term usefulness of the drug?

 Y N

Comments: \_\_\_\_\_

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

|                                |              |
|--------------------------------|--------------|
| <b>Prescriber's Signature:</b> | <b>Date:</b> |
|--------------------------------|--------------|