Prior Authorization Form

Amphetamines

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Amphetamines.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. 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, then no further questions are required.]

2. Is the medication being prescribed lisdexamfetamine (Vyvanse) or methamphetamine (Desoxyn)? Y N

[If the answer to this question is yes, then no further questions are required.]

3. Does the patient have the diagnosis of narcolepsy confirmed by a sleep study? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date