Prior Authorization Request Form for
methylphendiate (Cotempla XR ODT)

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Sponsor ID # ______________________ Phone #: ______________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Please note: Is the patient between the ages of 6-17 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and failed, or has a contraindication to generic Adderall XR?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed, or has a contraindication to generic Concerta OROS?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed or has a contraindication to Quillivant XR (methylphenidate ER oral suspension), or Aptensio XR (methylphenidate ER cap)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________ Prescriber Signature ______________ Date

[14 February 2018]

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: