Prior Authorization Request Form for
methylphenidate-hydrochloride extended-release **(Jornay PM)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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:**

1. Is the patient 6 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) that has been documented in the medical record?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had at least a 2 month trial and failure of Concerta (generic), or have difficulty swallowing pills?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient had at least a 2 month trial and failure of another long-acting methylphenidate (Methylphenidate ER/CD/LA, Quillivant XR, Aptensio XR)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient had at least a 2 month trial and failure of Adderall XR (generic)?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**
6. Does the patient have a contraindication to Adderall XR (generic)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried for at least two months, an immediate release formulation methylphenidate product in conjunction with Concerta or another long-acting methylphenidate?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for
methylphenidate-hydrochloride extended-releas **(Jornay PM)**

8. Please explain why the patient needs Jornay PM.	**Sign and date below**

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

Prescriber Signature _____ Date _____

[13 November 2019]

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