TRICARE Prior Authorization Request Form for
clonidine (Onyda XR)

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.

Prior Authorization does not expire.

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. What is the indication or diagnosis?	☐ Attention Deficit Hyperactivity Disorder (ADHD) – Proceed to Question **3** ☐ Other diagnosis – **STOP - Coverage not approved**	
3. Has the patient tried and failed, had an inadequate response, OR contraindication to amphetamine salts XR (Adderall XR, generic) or other long-acting amphetamine or derivative drug?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed, had an inadequate response, OR contraindication to methylphenidate OROS (Concerta, generic) or other long-acting methylphenidate or derivative drug?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a documented medical condition (for example, dysphagia, oral candidiasis, systemic sclerosis, autism spectrum disorder, etc.) where the patient is not able to swallow?	☐ Yes **Sign and date below**	☐ No Proceed to question **6**

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6. Has the patient tried and failed, had an inadequate response, OR contraindication to non-stimulant ADHD medication (generic formulation of Strattera or Intuniv)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed, had an inadequate response, OR contraindication to generic clonidine HCL extended-release tablet?	☐ 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

[12 February 2025]

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