TRICARE Prior Authorization Request Form for
dextroamphetamine transdermal system **(Xelstrym)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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:**

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 appropriately documented in the medical record?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the provider aware of warnings, screenings, and monitoring precautions for Xelstrym?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed or has a contraindication to one medication from each of the following categories: amphetamine (single or mixed salt medications) and methylphenidate?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a documented swallowing dysfunction requiring alternative formulation for treatment?	☐ 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 December 2022]

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