Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Intuniv Kapvay - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Intuniv Kapvay - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Clonidine extended-release	Guanfacine extended-release	Intuniv (guanfacine extended-release)
Kapvay (clonidine extended-release)		

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.	Is this request for continuation of therapy?	Y N
	[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	
	[If no, then skip to question 3.]	

2. Is the patient showing a beneficial response to treatment?	Y N	
[Note: Documentation must be provided.]		
[No further questions.]		
3. Does the patient have the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)?	Y N	
[Note: Documentation must be provided.]		
[If no, then no further questions.]		
4. Is the patient under 6 years of age?	Y N	
[If yes, then no further questions.]		
5. Is the patient between 6 years and 17 years of age?	Y N	
[If yes, then no further questions.]		
6. Has the patient demonstrated inadequate response or intolerance to at least 2 stimulant medications or Strattera?	Y N	
[Note: Documentation must be provided.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date