ATTENTION DEFICIT [HYPERACTIVITY] DISORDER (ADHD/ADD) AGENTS
STEP THERAPY REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this prior authorization form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
2. If the request is for Evekeo, has it been prescribed for the treatment of obesity? ☐ Yes ☐ No
3. If the request is for Vyvanse, has it been prescribed for the treatment of binge eating disorder? ☐ Yes ☐ No

For brand stimulant agents:

(Submit chart notes to support the answers to the following questions.)

4. Has the patient has tried and had an inadequate response to a generic stimulant agent? ☐ Yes ☐ No
5. Was a generic stimulant agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
6. Does the patient have an intolerance or hypersensitivity to ONE generic stimulant agent? ☐ Yes ☐ No
7. Does the patient have an FDA labeled contraindication to ALL generic stimulant agents? ☐ Yes ☐ No
8. Is a generic stimulant agent is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
9. Is a generic stimulant agent is not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
10. Has the patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic stimulant agents and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For brand non-stimulant agents:

(Submit chart notes to support the answers to the following questions.)

11. Has the patient tried and had an inadequate response to a generic stimulant agent OR generic non-stimulant agent (e.g., guanfacine ER, clonidine ER, atomoxetine)? ☐ Yes ☐ No
12. Was a generic stimulant agent OR generic non-stimulant agent (e.g., guanfacine ER, clonidine ER, atomoxetine) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
13. Does the patient have an intolerance or hypersensitivity to ONE generic stimulant agent OR generic non-stimulant agent (e.g., guanfacine ER, clonidine ER, atomoxetine)? ☐ Yes ☐ No
14. Does the patient have an FDA labeled contraindication to ALL generic stimulant agents AND generic non-stimulant agents (e.g., guanfacine ER, clonidine ER, atomoxetine)? ☐ Yes ☐ No
15. Is a generic stimulant agent OR generic non-stimulant agent (e.g., guanfacine ER, clonidine ER, atomoxetine) is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
16. Is a generic stimulant agent OR generic non-stimulant agent (e.g., guanfacine ER, clonidine ER, atomoxetine) is not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
17. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic stimulant agent OR generic non-stimulant agent (e.g., guanfacine ER, clonidine ER, atomoxetine) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
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Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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