NON-PREFERRED STIMULANT PRIOR AUTHORIZATION FORM

Coverage Criteria: To receive Concerta, Metadate CD, Ritalin LA, generic Adderall XR, or Strattera a patient would be required to first fail or have a documented contraindication to both methylphenidate and generic Adderall immediate release.

Authorization Period: 1 year

PLEASE FAX COMPLETED FORM TO: 1-877-548-7648

Patient Name:		**Member ID #**
******Member Phone Number******		
Date of Request:		**DOB:**
Requesting Physician:	**(website)**	**DEA #**
Office Phone #		**Office Fax #**

MEDICATION INFORMATION

1. **Please indicate drug requested:** ☐ **Concerta** ☐ **Metadate CD** ☐ **Ritalin LA** ☐ **Strattera** ☐ **generic Adderall XR**

2.

CURRENT/PAST MEDICATIONS/DOSAGES USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

Additional Comments:

Physician's Signature:

CHCH 5110-7(3/11)

For Urgent Requests please call (866) 847-8279

Visit our Websites at http://www.summithealthplan.com and http://www.vistahealthplan.com

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