Prior Authorization Form

CAREFIRST - DC EXCHANGE 5T

Intuniv-Kapvay Step Therapy REG (HMF)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Intuniv-Kapvay Step Therapy REG (HMF).

Drug Name (select from list of drugs shown)
Guanfacine ER

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 the requested drug being used to treat one of the following conditions: A) pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, B) pediatric acute onset neuropsychiatric syndrome?	Y N
[If yes, then no further questions.]	
2. Does the patient have the diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)?	Y N
[If no, then no further questions.]	

3.	Has the patient experienced an inadequate treatment response to an amphetamine product (e.g., amphetamine, amphetamine-dextroamphetamine, dextroamphetamine, methamphetamine, lisdexamfetamine) or a methylphenidate product (e.g., methylphenidate, dexmethylphenidate)?	Y N
	[If yes, then no further questions.]	
4.	Has the patient experienced an intolerance to an amphetamine product (e.g., amphetamine, amphetamine-dextroamphetamine, dextroamphetamine, methamphetamine, lisdexamfetamine) or a methylphenidate product (e.g., methylphenidate, dexmethylphenidate)?	Y N
	[If yes, then no further questions.]	
5.	Does the patient have a contraindication that would prohibit a trial of an amphetamine product (e.g., amphetamine, amphetamine-dextroamphetamine, dextroamphetamine, methamphetamine, lisdexamfetamine) and a methylphenidate product (e.g., methylphenidate, dexmethylphenidate)?	Y N

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