

Desoxyn[®] (methamphetamine) Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			F	Provider Information (required)			
Member Name:			Provider Nam	Provider Name:			
Insurance ID#:			NPI#:		Specialty:		
Date of Birth:			Office Phone	Office Phone:			
Street Address:			Office Fax:	Office Fax:			
City:	State:	Zip:	Office Street	Office Street Address:			
Phone:			City:	State:	Zip:		
Medication Information (required)							
Medication Name:			Strength:		Dosage Form:		
Check if requesting brand			Directions for	Directions for Use:			
Check if request is for continuation of therapy							
Clinical Information (required)							
Select the diagno	osis below:						
Attention Deficit Disorder with Hyperactivity							
Other diagnosis	s:		_ ICD-10 Code(s	CD-10 Code(s):			
Medication histor							
Has the patient had a trial and failure (after a minimum of a 60 day trial), contraindication, or intolerance to any four							
medications from any of the following options in the past 90 days? Yes No							
Atomoxe Guanfac							
	e salts product						
 Long-acting amphetamine salts product Long-acting methylphenidate product 							
Long do							
Are there any other control this review?	omments, diagnose	s, symptoms, medications	tried or failed, and/or	any other information	n the physician feels is importa	nt to	

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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