



**Independence
Blue Cross**

Prior Authorization Form

VYVANSE /INTUNIV/DAYTRANA/KAPVAY ER

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: Intuniv Vyvanse Daytrana Kapvay ER

Date: _____ Patient ID#: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

- Attention deficit hyperactivity disorder (ADHD)
- Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. PATIENT HISTORY

a. Has the patient tried and failed any of the following?

- | | | | |
|--|------------------------------|-----------------------------|------------------------------|
| Methylphenidate containing product | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Mixed amphetamine salts containing product (Adderall or Adderall XR) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Strattera | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Dextroamphetamine containing product | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Desoxyn | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Dexmethylphenidate containing product | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

b. Is there a history of or potential for drug abuse among the patient or the member of the household? Yes No N/A

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

**FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**