



Date of Request: \_\_\_\_\_

**Sterling Retiree Rx Prior Authorization Form****CONCERTA, AMPHETAMINE , DEXTROAMPHETAMINE, METADATE CD, METHYLIN, RITALIN LA, METHYLPHENIDATE****Coverage Criteria**

Attention Deficit Hyperactivity Disorder; Narcolepsy

Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances, and long-term usefulness.

**Required Medical Information**

Sleep studies for narcolepsy diagnosis

**Exclusion Criteria**

Non FDA approved use; MAOI concurrent use or use within last 14 days

**Member Information**

<b>Name</b>					
<b>Enrollment/Card-holder ID Number</b>					
<b>Group/Plan</b>		<b>Male</b>		<b>Female</b>	
<b>Date of Birth</b>		<b>Age</b>		<b>Weight in Kg</b>	
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	

**Physician Information**

<b>Name</b>					
<b>Agent</b>		<b>Contact Name</b>			
<b>Specialty/Office</b>					
<b>Clinic Name</b>					
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Phone</b>		<b>Fax</b>			

**Requested Drug**

	<b>Reason for Request</b>	
<b>Condition/Diagnosis Related</b>		

**Clinical Drug/Lab History Pertinent to Request**

<b>Labs: Baseline/Ongoing</b>	<b>Strength/Dosage</b>		
<b>Formulary Alternative(s) Attempted?</b>	<b>Yes:</b>		<b>No:</b>
<b>Please List Alternative Formulary Drugs</b>			

<b>Comments</b>	
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Physicians Signature: \_\_\_\_\_

Fax Form to 1-877-847-9904