



ADD/ADHD MEDICATIONS Methylphenidate HCl, Amphetamines (Ritalin, Methylin, Adderall, Concerta)

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of ADD/ADHD Medications. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. - Member Information:

Patient Name:		Plan Name:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone Number:	

B. - Physician Information

Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone Number:	Physician Fax Number:	
Drug Name and Strength:	Quantity and Days Supply:	NDC Number and GCN:	

C. - Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone Number:	Pharmacy Fax Number:
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D. - Clinical Information - Please fill out the following information: (circle all that apply)

- Does the patient have a current diagnosis of Attention Deficit (ADD) or Attention Deficit with Hyperactivity disorder (ADHD)? YES NO
- Does the patient have ADD/ADHD symptoms in more than one setting (ex. School, Work & Home)? YES NO
- Does the patient have a diagnosis of narcolepsy? YES NO
- Has the patient been evaluated for other causes of excessive daytime sleepiness (ex. Insufficient sleep syndrome, upper airway resistance syndrome, depression)? YES NO

Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To: ProCare PBM Clinical Division 3090 Premier Parkway Suite 100, Duluth, GA 30097
1-866-965-DRUG (3784)/ Fax # 800-662-0590

<u>FOR INTERNAL USE ONLY</u>		Help desk initials: _____
<input type="checkbox"/> Approved	Reviewed by: _____ Review Date: _____ Review Time: _____ Effective Date: _____	
<input type="checkbox"/> Denied	Termination Date: _____	