

Vyvanse Step Therapy

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice[®] HealthPlan

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax back to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant secure location.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program.

Caremark is an independent company that administers prescription drug benefits.

1. Is there a history of intolerance, significant adverse reaction or non-response to either generic stimulants or our preferred stimulants (Concerta, Metadate CD or Strattera)?
[If answer to this question is yes, then no further questions required.]

Y	N
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2. Is there a strong clinical suspicion of potential abuse which would be mitigated by a pro-drug (especially a history of nasal insufflation)?

Y	N
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Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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