PRIOR AUTHORIZATION REQUEST
Clonidine ER / Guanfacine ER

PATIENT: Name_______________________
Address: _______________________
City, State, Zip______________________
D.O.B. ______________________
Member ID:____________ _____________

Prescriber: Name_______________________
Address _______________________
City, State, Zip______________________
Phone ______________________
Fax ______________________
NPI ______________________

Medication Requested:____________ **Qty Requested: ____________**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1 ❑ Yes ❑ No Has the patient tried and failed behavioral therapy and environment manipulation for their condition?

2 ❑ Yes ❑ No Have the other medications been found clinically inappropriate for the patient's condition? ***(please specify):***____

3 ❑ Yes ❑ No Is there documentation to confirm that behavioral therapy and the manipulation of the environment have been unsuccessful and that the other medications are not medically appropriate for the patient's condition?

4 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
- ❑ INITIAL
- ❑ CONTINUATON

5 What is the indication or diagnosis?
- ❑ ADHD
- ❑ All other indications and diagnoses ***(please specify):***________________________________

6 ❑ Yes ❑ No Is there documentation to confirm that the patient is clinically stable on the requested medication?

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If you have any questions, call: 800-753-2851

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Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

PHYSICIAN SIGNATURE ______________________________ DATE ______________

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851