maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Clonidine ER/Guanfacine ER

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?

[] Initial (If checked, go to 2)

[] Continuation (If checked, go to 7)

2 What is the patient's age?

[] LESS THAN 6 years of age (If checked, go to 3)

[] GREATER THAN or EQUAL TO 6 years of age but LESS THAN or EQUAL TO 17 years of age (If checked, no further questions)

If you have any questions, call: 1-888-258-8250

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	[] GREATER THAN 17 years of age (If checked, go to 3)		
3	What is the indication or diagnosis? [] Attention deficit hyperactivity disorder (ADHD) (If checked, go to 4) [] Other (If checked, no further questions)		
4	Has the patient tried and failed behavioral therapy and environment manipulation for their condition? [If no, no further questions.]	Yes	No
5	Have the other medications been found clinically inappropriate for the patient's condition? [If no, no further questions.]	Yes	No
6	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? [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Attention deficit hyperactivity disorder (ADHD) (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is there documentation to confirm that the patient is clinically stable on the requested medication?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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.

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