



PRIOR AUTHORIZATION REQUEST

Clonidine ER and 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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
	<input type="checkbox"/> Initial (If checked, go to 2)
	<input type="checkbox"/> Continuation (If checked, go to 7)
2	What is the patient's age?
	<input type="checkbox"/> LESS THAN 6 years of age (If checked, go to 3)

If you have any questions, call:
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GREATER THAN or EQUAL TO 6 years of age but LESS THAN or EQUAL TO 17 years of age (If checked, no further questions)

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? Yes No
[If no, no further questions.]

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? Yes No
[No further questions.]

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

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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.

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