



Prior Authorization Form

VYVANSE /INTUNIV/DAYTRANA/KAPVAY ER

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [] Intuniv [] Vyvanse [] Daytrana [] Kapvay ER
Date: Patient ID#: DOB:
Patient Name: Provider NPI:
Prescribing Physician: Office Contact:
Office Fax #: Office Phone:

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1. DIAGNOSIS FOR DRUG REQUESTED:

- [] Attention deficit hyperactivity disorder (ADHD)
[] Other (specify)

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration

3. PATIENT HISTORY

a. Has the patient tried and failed any of the following?

- Methylphenidate containing product [] Yes [] No [] N/A
Mixed amphetamine salts containing product (Adderall or Adderall XR) [] Yes [] No [] N/A
Strattera [] Yes [] No [] N/A
Dextroamphetamine containing product [] Yes [] No [] N/A
Desoxyn [] Yes [] No [] N/A
Dexmethylphenidate containing product [] Yes [] No [] N/A

b. Is there a history of or potential for drug abuse among the patient or the member of the household? [] Yes [] No [] N/A

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL