

ADHD (Non-Stimulant)

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet		Date: ____ / ____ / ____		
To: <u>Wellmark Pharmacy Services</u>	From (Prescriber's Name): _____			
Fax Number: <u>(866) 884-4345</u>	Prescriber's DEA Number: _____			
Phone Number: <u>(800) 600-8065</u>	Prescriber's Phone Number: _____			
Prescriber's Specialty: _____	Prescriber's Fax Number: _____			
Prescriber's Office Address: _____				
	Street	Suite #	City	State Zip
Patient Name: _____				
Patient ID: _____		Patient DOB: ____ / ____ / ____		

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____

2. Please indicate which medication is being requested: Intuniv Kapvay

3. Please list the previous stimulant medications (Ritalin, Focalin, Adderall, Concerta, etc.) that the patient has tried **OR** if the patient is unable to take stimulant medications, please explain why: _____

4. For Intuniv requests: Has the patient used guanfacine immediate-release (Tenex) in the past without success OR is the patient unable to take guanfacine immediate-release?

Yes, explain reason for discontinuation: _____
 No

Printed Name

Signature

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