Prescriber Criteria Form

HRM Guanfacine ER 2024 PA Fax 3520-B v1 010124.docx
High Risk Medications
Guanfacine extended-release
This HRM List Applies To Formulary Drugs Only.
Prior Authorization applies only to patients 70 years of age or older
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Guanfacine extended-release.

Drug Name:
Guanfacine extended-release

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of attention deficit hyperactivity disorder (ADHD)? [If no, then no further questions.]	Yes	No
2	The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____