Prescriber Criteria Form

Amphetamines 2024 PA Fax 1383-A v1 010124.docx
Amphetamines
Adderall, Adderall XR, Mydayis (amphetamine mixture), Adzenys XR-ODT, Dyanavel XR, Evekeo ODT (amphetamine), Dexedrine Spansule, Procentra, Zenzedi (dextroamphetamine sulfate), Xelstrym (dextroamphetamine)
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 Amphetamines.

Drug Name (select from list of drugs shown):

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	Does the patient have a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of narcolepsy confirmed by a sleep study?	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:**_____