DEXTROSTAT

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM
BlueCross BlueShield of South Carolina

Patient Information	
Name:	**Insurance ID #:**
Group #:	**Birthdate:**

Provider Information	
Physician's Name:	**Physician DEA #:**
Phone:	**Fax:**
Office Address:	
Diagnosis:	**ICD-9 Code:**

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the patient 3 years old or older? Y N
2. Does the patient have a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD)? Y N
3. Does the patient have a diagnosis of Narcolepsy? Y N
4. Has the diagnosis been confirmed by sleep studies? Y N
5. Has the patient been evaluated for other causes of excessive daytime sleepiness (e.g., insufficient sleep syndrome, upper airway resistance syndrome, depression)? Y N

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6. Does the patient have ADHD symptoms in more than one setting (e.g., school or work, home)? Y N
7. Has the patient had ADHD symptoms for longer than 6 months? Y N
8. Are the ADHD symptoms causing clinically significant impairment in social, academic, or occupational functioning? Y N
9. Have other primary psychiatric disorders and/or secondary enviornment factors been considered for the cause of the ADHD symptoms? Y N
10. Will amphetamine therapy be used as an integral part of a total treatment program that may include psychological, educational and social measures? Y N
11. Is the physician aware of the contraindication to the use of monoamine oxidase inhibitor (MAOI) drugs within 14 days of amphetamine therapy? Y N
12. Will the patient be regulary monitored for adverse events, including weight loss and decreased growth velocity for children, and long-term usefulness? Y N

Comments: ____

Information on this form is accurate as of the date below.

Prescriber's Signature:	**Date:**

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