STRATTERA

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 6 years old or older? Y N
2. Does the patient have a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD)? Y N
3. Will the patient be on a monoamine oxidase inhibitor (MAO) drug while taking this therapy or has the patient been on an MAOI drug in the previous 14 days? Y N

   [MAOI drugs include: phenelzine (Nardi), tranylcypromine (Pamate), isocarboxazid (Marplan) selegiline (Eldepryl, Emsam)]
4. Will the patient be regularly monitored for adverse events, including liver injury, weight loss and decreased growth velocity for children, increased heart rate and blood pressure, the appearance of worsening of aggressive behavior or hostility, and sleep disturbances? Y N

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5. Will the patient be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior? Y N

Comments: ____

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

Prescriber's Signature:	**Date:**

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