US Family Health Plan
Prior Authorization Request Form for
methylphendiate (**Cotempla XR ODT**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Please note: Is the patient between the ages of 6-17 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and failed, or has a contraindication to generic Adderall XR?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed, or has a contraindication to generic Concerta OROS?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed or has a contraindication to Quillivant XR (methylphenidate ER oral suspension), or Aptensio XR (methylphenidate ER cap)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[14 February 2018]