US Family Health Plan
Prior Authorization Request Form for methylphenidate-hydrochloride extended-release **(Jornay PM),** serdexmethylphenidate/dexmethylphenidate **(Azstarys)**

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. Is the patient 6 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) that has been documented in the medical Record?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had at least a 2 month trial and failure of Concerta (generic), or have difficulty swallowing pills?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient had at least a 2 month trial and failure of another long-acting methylphenidate (Methylphenidate ER/CD/LA, Quillivant XR, Aptensio XR)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient had at least a 2 month trial and failure of Adderall XR (generic)?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**
6. Does the patient have a contraindication to Adderall XR (generic)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried for at least two months, an immediate release formulation methylphenidate product in conjunction with Concerta or another long-acting methylphenidate?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Please explain why the patient needs Jornay PM or Azstarys.	_____ **Sign and date below**

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

_____ _____
Prescriber Signature Date