US Family Health Plan
Prior Authorization Request Form for
Clonidine (Onyda XR)

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**

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Clinical documentation may be required for review.
Prior Authorization does not expire.

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:**

Question		
1. **Is the patient 6 years of age or older?**	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. **What is the indication or diagnosis?**	☐ Attention Deficit Hyperactivity Disorder (ADHD) – Proceed to Question **3** ☐ Other diagnosis – **STOP - Coverage not approved**	
3. **Has the patient tried and failed, had an inadequate response, OR contraindication to amphetamine salts XR (Adderall XR, generic) or other long-acting amphetamine or derivative drug?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Has the patient tried and failed, had an inadequate response, OR contraindication to methylphenidate OROS (Concerta, generic) or other long-acting methylphenidate or derivative drug?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Does the patient have a documented medical condition (for example, dysphagia, oral candidiasis, systemic sclerosis, autism spectrum disorder, etc.) where the patient is not able to swallow?**	☐ Yes **Sign and date below**	☐ No Proceed to question **6**

6. Has the patient tried and failed, had an inadequate response, OR contraindication to non-stimulant ADHD medication (generic formulation of Strattera or Intuniv)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed, had an inadequate response, OR contraindication to generic clonidine HCL extended-release tablet?	☐ 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

[12 February 2025]