



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

AMPHETAMINE SALTS, DEXTROAMPHETAMINE, METHYLPHENIDATE

Coverage Criteria

Attention Deficit Hyperactivity Disorder; Narcolepsy
(Consider benefits of use versus the potential risks of serious cardiovascular events.)

Required Medical Information

Sleep studies for narcolepsy diagnosis

Exclusion Criteria

Non FDA approved use; MAOI concurrent use or use within last 14 days; less than 3 years of age; greater than 6 years of age for methylphenidates

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage			
Formulary Alternative(s) Attempted?	Yes:		No:	
Please List Alternative Formulary Drugs				

Comments	
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Physicians Signature: _____

Fax Form to 1-866-481-3704