



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

STRATTERA (Atomoxetine)

Coverage Criteria

Attention Deficit Hyperactivity Disorder **and** ≥ 6 years of age
Monitor for suicidal tendencies, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, weight loss, decreased growth velocity in children, sleep disturbances, liver injury.

Exclusion Criteria

Concurrent use of MAOI or use of MAOI within last 14 days

Member Information

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

Physicians Information

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

Requested Drug

| | | |
|-----------------------------|--------------------|--|
| STRATTERA | 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 | | | |
| | | | |
| | | | |

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| Comments | |
|----------|--|

Physicians Signature: _____ Fax Form to 1-866-481-3704