

Prescriber Criteria Form

Dexmethylphenidate 2026 PA Fax 4336-A v1 010126.docx
Dexmethylphenidate Products
Focalin, Focalin XR (dexmethylphenidate hydrochloride)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Dexmethylphenidate Products.

Drug Name (select from list of drugs shown):

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____