Prescriber Criteria Form
Methylphenidate 2026 PA Fax 3642-A v1 010126.docx
Methylphenidate Products
Aptensio XR, Concerta, Cotempla XR-ODT, Daytrana, Jornay PM, Metadate CD, Methylin, Quillichew ER, Quillivant XR, Relexxii, Ritalin, Ritalin LA (methylphenidate), Methylin (methylphenidate) all products
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 Methylphenidate 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	Does the patient have a diagnosis of narcolepsy confirmed by a sleep study? [If yes, then no further questions.]	Yes	No
3	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:**_____