Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Metadate CD

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Metadate CD.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(please circle)***

Metadate CD (methylphenidate, biphasic release)

Other, please specify____

Quantity ___________ Frequency ________________ Strength ____________

Route of Administration ___________ Expected Length of therapy _______________

Patient Information

Patient Name: ____________________________________

Patient ID: ____________________________________

Patient Group No.: ____________________________________

Patient DOB: ____________________________________

Patient Phone: ____________________________________

Prescribing Physician

Physician Name: ____

Specialty: ____________________________ NPI Number: __________________________

Physician Fax: ____________________________ Physician Phone: __________________________

Physician Address: ____________________________ City, State, Zip: __________________________

Diagnosis:______________________________ **ICD Code:**______________________________

Please circle the appropriate answer for each question.

1. Is the patient 6 years of age or older? Y N
   [If no, then use stimulants for under 6 year old criteria.]

2. Does the patient have a diagnosis of attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)? Y N

3. Has the patient had recent history of Metadate CD therapy for the past two months as documented by claims history or physicians notes demonstrating compliance? Y N
   [If yes, then no further questions.]

4. Has the patient had a documented trial and failure of at least two other intermediate-acting methylphenidate preparations (i.e., Metadate ER, Methylin ER, methylphenidate SA) within the past 365 days? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**