Physician Request Form for ADHD Medications
Fax to Pharmacy Services at **855-829-2872**, or call **855-251-0966**
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Delaware

Member name:_____ Member ID: _____

Member address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Physician name: _____ NPI: _____

Physician address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Contact name: _____

Physician specialty: _____

Requested drug name, strength and dosage form:_____

Day Supply: _____ Number of Refills: _____

Directions: _____

- Is the patient 21 years of age or older? ☐Yes ☐No
- Does the member have a diagnosis of attention deficit hyperactivity disorder (ADHD)? ☐Yes ☐No
- Has the Diagnostic and Statistical Manual of Mental Disorders V (DSM-5) criteria for ADHD been met? ☐Yes ☐No
- Were behavioral modification techniques tried prior to medication being prescribed?: ☐ Yes ☐ No
- Is the member currently taking a benzodiazepine? ☐Yes ☐No

  If yes, what is the name of the benzodiazepine? _____

  For what diagnosis is the member taking a benzodiazepine?_____

  If yes, please provide justification for the use of an ADHD medication and a benzodiazepine:

  _____
- Is the member on both a long acting and short acting version of the same ADHD medication? ☐Yes ☐No

  If yes, please provide justification for the use of a long acting and short acting version of the same ADHD medication:

  _____
- Has the member tried and failed any medication(s) for attention deficit hyperactivity disorder (ADHD)? ☐Yes ☐No

  If yes, please list the medication(s): _____
- If the request is for a non-preferred medication please indicate why a preferred medication cannot be used:

  _____

Physician Signature: _____ **Print Name:** _____ **Date**: _____

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