

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
DAYTRANA(methylphenidate)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and opt. _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ Available for ages 6 through 18
- ▶ Documentation of physical inability to swallow.

OR

- ▶ Documentation that patient is currently on a combination of two stimulants or stimulant(s) and Strattera or that patient is on two different strengths of the same ADD/ADHD medication - Daytrana must be a more cost-effective therapy.
- ▶ Prior authorization will not be granted if the client has had an allergic reaction on other methylphenidate formulations.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated Letter of Medical Necessity.