



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Intuniv® (guanfacine extended-release [ER])

Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Attention deficit hyperactivity disorder (ADHD)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<i>The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.</i>					
Risk acknowledgment:					
Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.					
Select the medications the patient has a failure, contraindication, or intolerance to:					
<input type="checkbox"/> Adderall	<input type="checkbox"/> Guanfacine ER				
<input type="checkbox"/> Adderall XR	<input type="checkbox"/> Metadate ER				
<input type="checkbox"/> Adzenys ER	<input type="checkbox"/> Methylin				
<input type="checkbox"/> Adzenys XR-ODT	<input type="checkbox"/> Methylphenidate (generic Ritalin)				
<input type="checkbox"/> Amphetamine	<input type="checkbox"/> Methylphenidate chewable tablet				
<input type="checkbox"/> Amphetamine-dextroamphetamine	<input type="checkbox"/> Methylphenidate controlled-release (CD) (generic Metadate CD)				
<input type="checkbox"/> Amphetamine-dextroamphetamine ER	<input type="checkbox"/> Methylphenidate ER (10mg, 20mg tablets)				
<input type="checkbox"/> Aptensio XR	<input type="checkbox"/> Methylphenidate ER (18mg, 27mg, 36mg, 54mg tablets)				
<input type="checkbox"/> Concerta	<input type="checkbox"/> Methylphenidate ER (72mg tablet)				
<input type="checkbox"/> Cotelma XR-ODT	<input type="checkbox"/> Methylphenidate ER (generic Ritalin LA)				
<input type="checkbox"/> Daytrana	<input type="checkbox"/> Methylphenidate solution				
<input type="checkbox"/> Dexedrine	<input type="checkbox"/> Mydayis				
<input type="checkbox"/> Dexmethylphenidate	<input type="checkbox"/> Procentra				
<input type="checkbox"/> Dexmethylphenidate ER	<input type="checkbox"/> Quillichew ER				
<input type="checkbox"/> Dextroamphetamine	<input type="checkbox"/> Quillivant XR				
<input type="checkbox"/> Dextroamphetamine ER	<input type="checkbox"/> Relexxii				
<input type="checkbox"/> Dyanavel XR	<input type="checkbox"/> Ritalin				
<input type="checkbox"/> Evekeo	<input type="checkbox"/> Vyvanse				
<input type="checkbox"/> Focalin	<input type="checkbox"/> Zenzedi				
<input type="checkbox"/> Focalin XR					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Intuniv-guanfacineER_CMS_2019Feb-V



Intuniv[®] (guanfacine extended-release [ER])
Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.