



RxAmerica
 221 N. Charles Lindbergh Dr.
 Salt Lake City, UT 84122-9902
 Phone (866) 453-1999 Fax: (866) 514-1715

Minnesota Health Care Programs Prior Authorization Request Form
 Amphetamines

● ● ● Only one medication request per form ● ● ● All fields must be complete and legible for review ● ● ●

<input type="checkbox"/> STANDARD REVIEW		<input type="checkbox"/> EXPEDITED REVIEW	
By selecting the expedited review and signing this form below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.			
PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name:		Prescriber Name and Specialty:	
Member ID#:		DEA #:	
Sex (circle): Male Female		Office Phone:	
Date of Birth:		Office Fax:	
Patient Phone:		Contact Person:	
PHARMACY INFORMATION			
Pharmacy Name:	NABP#:	PHARMACY PHONE NO:	PHARMACY FAX NO:
DIAGNOSIS AND MEDICAL INFORMATION			
Medication:	Strength and Route of Administration:	Frequency:	
<input type="checkbox"/> New Prescription – OR – Date Therapy Initiated: / /	Expected Length of Therapy:	Quantity:	
Height & Weight:	Drug Allergies:	Diagnosis Related to Medication Requested:	
Rationale for Prior Authorization Request			
Medical Justification for amphetamine:			
1. Does the patient have a current diagnosis of attention deficit disorder (ADD) or attention deficit with hyperactivity disorder (ADHD)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
2. Does the patient have a current diagnosis of narcolepsy? <input type="checkbox"/> YES <input type="checkbox"/> NO			
3. Does the patient have a current diagnosis of major depressive disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Prescriber's Signature:		Date:	