Phoenix Benefits Management manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the questions below and fax this form back to **888.835.3383**. Please note any information left blank or illegible could delay the review process.

ADHD MEDICATION REVIEW

Member Name: Provider Name:

ID Number: Provider NPI:

Rx GRP: Provider Phone:

Date of Birth: Provider Fax:

Patient Follow Up Appointment Date:

Medication Name, Dosage and Directions: Diagnosis:

Please attach all pertinent medical history or information for this patient that may help in the review process. Please answer the following questions:

Is this a current medication? If yes, how long has the patient been taking? Any side effects?

List all medications the patient has tried in the past to treat this condition. Some medications may be required prior to the approval of other medications.

Please provide the following information for the patient:

Weight Blood Pressure

Heart Rate Respiratory Rate

If the patient has been currently taking this medication have they had any behavioral or mood changes?

Physician Signature: Date: