

Desoxyn<sup>®</sup> (methamphetamine)  
 Prior Authorization Form



**Complete Patient and Physician information (PLEASE PRINT)**

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

**If Applicable:** Pharmacy Name: \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

STEP 2	Diagnosis	<input type="checkbox"/> ADHD <input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Other (please state): _____  <b>Desoxyn is not covered for treatment of obesity</b>
	Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):	
		Please attach a copy of the prescription or provide ALL of the information below: Desoxyn <sup>®</sup> (methamphetamine) Strength _____ Sig _____ Qty _____ Refills _____	
Please attach all relevant medical records and test results. <b>Incomplete forms will not be processed.</b>			

**I certify that the above is correct and accurate to the best of my knowledge (please sign and date).**

STEP 3	_____	_____
	Prescriber Signature	Date

**STEP 4 Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:  
 970-248-5034**

Pharmacy Technician initials \_\_\_\_\_ Date Initiated \_\_\_\_\_

**Confidentiality Notice:**

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