

Prior Authorization (PA) Form for Stimulants/ADHD Medications for Children Less Than FDA Indicated Age and Adults Over 18

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If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member:

- **Preferred stimulants/ADHD medications for individuals four (4) to 17 years of age do not require prior authorization. The member must meet the minimum FDA-approved age.**
- **If your request is for a non-preferred non-stimulant, please go to question 4 and submit form.**
- **Stimulants prescribed for children under the age of four (4) must be prescribed by a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists.**

Member information

Last name:	First name:
Medicaid ID number:	Date of birth:
Weight in kilograms:	

Prescriber information

Last name:	First name:
NPI number:	
Phone number:	Fax number:

(Form continued on next page.)

Member's last name:	Member's first name:

If the child is under 4 and you are prescribing a stimulant:

Are you a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists?

Yes No

Drug information

Drug name/form: _____

Strength:

Dosing frequency:

Length of therapy:

Quantity per day:

Diagnosis and medical information

Stimulants/ADHD medications for adults over 18 – to receive an approval for this drug, complete the following questions. This does not apply to non-stimulant ADHD medications (such as atomoxetine, clonidine ER, Kapvay®, guanfacine ER, Intuniv®, Qelbree®, etc.).

Does the member meet the following criteria?

1. Indicate the diagnoses being treated (include all ICD codes if applicable):

2. Did the prescriber use the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition and determine that criteria have been met (including documentation of impairment in more than one major setting) to make the diagnosis of ADHD?

Yes No

(Form continued on next page.)

Member's last name:	Member's first name:

Does the member meet the following criteria for the maintenance request?

3. The prescriber has regularly evaluated the member for stimulant or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate healthcare provider, or referred the member for evaluation for treatment if indicated.
 Yes No

To request a non-preferred agent, please answer the questions below, providing all requested information.

4. For non-preferred stimulants/ADHD medications, list pharmaceutical agents attempted and outcome:

5. Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this member.

Prescriber signature (required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include all requested information; incomplete forms will delay the PA process.
Submission of documentation does **not** guarantee coverage.

The completed form may be faxed to **844-512-7020**.