

**STIMULANTS AND RELATED AGENTS PRIOR AUTHORIZATION FORM**

To review the prior authorization guidelines for Stimulants and Related Agents, please refer to Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Stimulants and Related Agents** at <http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name & specialty:	
<input type="checkbox"/> Renewal request	# of pages in request: _____	State license #:	NPI:
Name/phone # of office contact:		Street address:	
LTC facility contact/phone:		Suite #:	City/state/zip:
Recipient Name:		Phone:	Fax:
Recipient ID#:	DOB:		

**CLINICAL INFORMATION**

**Medication Requested** (Names in parentheses are the brand name equivalents for reference purposes. IR = immediate-release; ER/XR = extended-release)

Preferred Agents		Non-Preferred Agents	
<input type="checkbox"/> Adderall tablet	<input type="checkbox"/> methylphenidate IR tablet (Ritalin)	<input type="checkbox"/> Aptensio XR capsule	<input type="checkbox"/> dextroamphetamine sol'n (ProCentra)
<input type="checkbox"/> Adderall XR	<input type="checkbox"/> methylphenidate ER/SR tablet (Ritalin-SR)	<input type="checkbox"/> clonidine ER tablet (Kapvay)	<input type="checkbox"/> methylphenidate chew (Methylin)
<input type="checkbox"/> amphetamine mixed salts IR tablet (Adderall)	<input type="checkbox"/> methylphenidate ER 24-hour tab (Concerta) (AHP & Actavis manufacturers only)	<input type="checkbox"/> Concerta tablet	<input type="checkbox"/> methylphenidate CD capsule (Metadate CD)
<input type="checkbox"/> Daytrana patch	<input type="checkbox"/> Quillivant XR suspension	<input type="checkbox"/> Desoxyn tablet	<input type="checkbox"/> methylphenidate ER capsule (Ritalin LA)
<input type="checkbox"/> dextroamphetamine IR tablet (Dexedrine IR, Dextrostat)	<input type="checkbox"/> Strattera capsule	<input type="checkbox"/> Dexedrine Spansule ER	<input type="checkbox"/> methylphenidate solution (Methylin)
<input type="checkbox"/> Focalin tablet	<input type="checkbox"/> Vyvanse capsule	<input type="checkbox"/> Dexedrine IR tablet	<input type="checkbox"/> ProCentra solution
<input type="checkbox"/> Focalin XR capsule		<input type="checkbox"/> dexmethylphenidate IR tablet (Focalin)	<input type="checkbox"/> Ritalin tablet
<input type="checkbox"/> Metadate CD capsule		<input type="checkbox"/> dexmethylphenidate XR cap (Focalin XR)	<input type="checkbox"/> Ritalin LA capsule
		<input type="checkbox"/> dextroamphetamine ER cap (Dexedrine Spansule)	<input type="checkbox"/> Zenzedi tablet
<input type="checkbox"/> dextroamphetamine mixed salts combo XR capsule (Adderall XR)			
		<input type="checkbox"/> Evekeo tablet	
		<input type="checkbox"/> Intuniv tablet	
		<input type="checkbox"/> Kapvay tablet	
		<input type="checkbox"/> methamphetamine tablet	
		<input type="checkbox"/> Methylin chewable	
		<input type="checkbox"/> Methylin solution	

Strength:	Directions:	Quantity:	# months requested:
Diagnosis:		Diagnosis code (required):	

**Request for a Non-Preferred Agent:**

1. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred Stimulants & Related Agents (listed above)?	<input type="checkbox"/> Yes – <u>submit documentation of drug regimens failed, contraindications, and intolerances</u> <input type="checkbox"/> No
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**Request for a Recipient LESS than 4 Years of Age:**

1. Does the Recipient have one of the following diagnoses? <i>Check all that apply.</i> <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Brain injury	<input type="checkbox"/> Yes – <u>Submit documentation of diagnosis.</u> <input type="checkbox"/> No – <u>Submit medical literature supporting the use of the requested medication for the Recipient's age and diagnosis</u>
2. Is the requested medication prescribed by, or in consultation with, one of the following specialists? <input type="checkbox"/> Pediatric Neurologist <input type="checkbox"/> Child/Adolescent Psychiatrist <input type="checkbox"/> Child Development Pediatrician	<input type="checkbox"/> Yes <input type="checkbox"/> No (prescriber's specialty: _____)
3. Has the Recipient had a comprehensive evaluation by, or in conjunction with, the above specialist?	<input type="checkbox"/> Yes – <u>submit documentation of evaluation</u> <input type="checkbox"/> No
4. <i>Strattera requests:</i> What is the Recipient's weight?	weight: _____ lbs / kg    date: _____

**Request for a Recipient 18 Years of Age and Older:**

1. What is the Recipient's diagnosis?	<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> <b>Initial request</b> – <u>submit documentation of an initial evaluation that shows a history of symptoms that meet the current DSM criteria (note: a rating scale alone is not sufficient documentation)</u> <input type="checkbox"/> <b>Renewal request</b> – <u>submit documentation supporting the continued need for the medication to manage symptoms</u> <input type="checkbox"/> Narcolepsy – <u>submit documentation of Recipient's symptom history and results of an overnight sleep study (a PSG) AND a Multiple Sleep Latency Test (MSLT)</u> <input type="checkbox"/> Moderate to Severe Binge Eating Disorder (Vyvanse request) <input type="checkbox"/> <b>Initial request</b> – <u>submit documentation of ALL of the following: an initial evaluation that shows a history of symptoms that meet the current DSM criteria; if the Recipient does NOT have ADD/ADHD, the Recipient has tried, or cannot try, SSRIs or topiramate, AND an offer of referral for cognitive behavioral therapy or other psychotherapy</u> <input type="checkbox"/> <b>Renewal request</b> – <u>submit documentation that the Recipient experienced a reduction in binge eating</u>
2. <i>Stimulant requests:</i> Does the Recipient have a history of or currently have substance use disorder [SUD] (drugs OR alcohol)?	<input type="checkbox"/> Yes <u>submit documentation of a recent evaluation</u> <input type="checkbox"/> No <u>for current or past substance use</u>
3. <i>For Recipients with a history of or current SUD,</i> does the Recipient have documentation of active participation in, or successful completion of, a substance use disorder treatment program?	<input type="checkbox"/> Yes – <u>submit documentation of treatment</u> <input type="checkbox"/> No or N/A
4. <i>For Recipients with a history of or current SUD,</i> does the Recipient have documentation of a recent urine drug screen (UDS) that is negative for non-prescribed benzodiazepines, opiates, and illicit drugs?	<input type="checkbox"/> Yes – <u>submit documentation of test results</u> <input type="checkbox"/> No or N/A

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b>	<b>Date:</b>
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