Prior Authorization Request Form for Stimulant and Related Agents

FAX this completed form to (844) 205-3386

OR Mail requests to: PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Did the prescriber or prescriber's delegate search the PDMP to review the member's controlled substance prescription history before issuing this prescription for the requested agent?	☐ Yes ☐ No
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Stimulant and Related agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No *Medication Taken Previously (start and end date and dose):* [redacted]

- ☐ Member has a current history (within past 90 days) of using the prescribed the requested non-preferred Stimulant and Related agent:_____
- ☐ Member was assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by prescribing provider
- ☐ Member has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction
- ☐ For member's with a history of comorbid substance dependency, abuse, or diversion has results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including oxycodone, fentanyl and tramadol)
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

Therapeutic Duplication:

If concurrently prescribed a therapeutic duplicate (i.e. stimulant different from the agent being requested):

- ☐ Member is transitioned from one stimulant and related agent to another with the intent of discontinuing one of the medications
- ☐ Member has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines. Supporting evidence:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD):

- ☐ Member has a diagnosis of ADHD confirmed according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria

MODERATE TO SEVERE BINGE EATING DISORDER:

- ☐ Member has a diagnosis of moderate to severe binge eating disorder confirmed according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria
- ☐ Member does not have ADHD and has documented history of therapeutic failure, contraindication or intolerance to at least 1 of the following: (medication, start date and end date)
  - ☐ Topiramate: _____
  - ☐ Selective Serotonin Reuptake Inhibitor (SSRI): _____
- ☐ Member has a documentation of a referral for cognitive behavioral therapy or other psychotherapy

NARCOLEPSY:

- ☐ Member has a diagnosis of narcolepsy confirmed according to the most recent consensus treatment guidelines (e.g. American Academy of Sleep Medicine International Classification of Sleep Disorders)

RENEWAL REQUESTS:

- ☐ Documentation of tolerability and experienced a positive clinical response to requested medication evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

PA Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)