

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 OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

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	ç):		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 t			□ Yes			
review the member's controlled substance prescription histor before issuing this prescription for the requested agent?			🗆 No			
Requests for all non-preferred medications : Does the mem have a history of trial and failure of or contraindication or into to the preferred Stimulant and Related agents? <i>Refer to</i> <u>https://papdl.com/preferred-drug-list</u> for a list of preferred and preferred medications in this class.			□ Yes □ No	Medication Taken Previously (start and end date and dose):		
 Member has a current history (within past 90 days) of using the prescribed the requested non-preferred Stimulant and Related agent:						
SUBMIT MEDICAL RECORD INFORMATIO ATTENTION DEFICIT HYPERACTIVITY D Member has a diagnosis of ADHD co Disorders (DSM) criteria	ISORDER (ADHD):			tic and Statistical Manual of Mental		

MODERATE TO SEVERE BINGE EATING DISORDER:		
Member has a diagnosis of moderate to severe binge Statistical Manual of Mental Disorders (DSM) criteria	eating disorder confirmed according to the	current Diagnostic and
 Member does not have ADHD and has documented his least 1 of the following: (medication, start date and er Topiramate:	story of therapeutic failure, contraindication and date)	n or intolerance to at
Selective Serotonin Reuptake Inhibitor (SSRI):		
Member has a documentation of a referral for cognitive NARCOLEPSY:	ve behavioral therapy or other psychothera	ару
Member has a diagnosis of narcolepsy confirmed acco American Academy of Sleep Medicine International C RENEWAL REQUESTS:		ent guidelines (e.g.
Documentation of tolerability and experienced a posit by:	ive clinical response to requested medicat	on evidenced
IV. ADDITIONAL RATIONALE FOR REQUEST / PERTI	NENT 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.)