pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs – Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

STIMULANTS AND RELATED AGENTS PRIOR AUTHORIZATION FORM (*Form effective 1/28/19*)

Prior authorization guidelines are accessible on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # of pgs: _____	Prescriber name/specialty:	
Name/phone of office contact:		State license #:	NPI:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

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

Preferred Agents

- ☐amphetamine mixed salts IR tablet (*Adderall*)
- ☐Aptensio XR capsule
- ☐atomoxetine capsule
- ☐Daytrana patch
- ☐dextroamphetamine ER cap
- ☐dextroamphetamine IR tablet (*Dexedrine IR*)
- ☐dextroamphet/amphetamine mixed salts combo XR capsule (*Adderall XR*)
- ☐Focalin tablet
- ☐Focalin XR capsule
- ☐guanfacine ER tablet
- ☐methylphenidate IR tablet (Ritalin)
- ☐methylphenidate ER/SR tablet (*Ritalin-SR*)
- ☐methylphenidate ER 24-hour tab (*Concerta*) (Actavis manufacturer only)
- ☐Quillichew ER tablet
- ☐Quillivant XR suspension
- ☐Vyvanse capsule
- ☐Vyvanse chewable tablet

Non-Preferred Agents

- ☐Adderall tablet
- ☐Adderall XR capsule
- ☐Adzenys ER suspension
- ☐Adzenys XR-ODT
- ☐clonidine ER tablet (*Kapvay*)
- ☐Concerta tablet
- ☐Cotempla XR-ODT
- ☐Desoxyn tablet
- ☐Dexedrine Spansule ER
- ☐dexmethylphenidate IR tablet (*Focalin*)
- ☐dexmethylphenidate XR cap (*Focalin XR*)
- ☐dextroamphetamine sol'n (*ProCentra*)
- ☐Dyanavel XR suspension
- ☐Evekeo tablet
- ☐Intuniv tablet
- ☐Kapvay tablet
- ☐methamphetamine tablet
- ☐Methylin solution
- ☐methylphenidate chew (*Methylin*)
- ☐methylphenidate CD capsule (*Metadate CD*)
- ☐methylphenidate ER capsule (*Ritalin LA*)
- ☐methylphenidate ER 72 mg tablet
- ☐methylphenidate solution (*Methylin*)
- ☐Mydayis ER capsule
- ☐ProCentra solution
- ☐Relexxii ER tablet
- ☐Ritalin tablet
- ☐Ritalin LA capsule
- ☐Strattera capsule
- ☐Zenzedi tablet
- ☐_____

Strength:	Directions:	Quantity:	# months requested:
Weight (if <4 years old):	Diagnosis:		Diagnosis code (*required*):

1. Did the prescriber or prescriber's delegate search the PDMP to review the beneficiary's controlled substance prescription history before issuing this prescription for the requested agent?	☐Yes ☐No *Submit documentation.*
2. ***If request is for a NON-PREFERRED agent***, does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred agents (listed above)?	☐Yes – *Submit documentation.* ☐No **---OR---** ☐not applicable
3. *If request for a NON-PREFERRED agent,* has the beneficiary been taking the requested non-preferred medication within the past 90 days?	☐Yes ☐No *Submit documentation of drug regimen and clinical response.*

Request for a Beneficiary LESS than 4 Years of Age

1. Does the beneficiary have one of the following diagnoses? *Check all that apply.* ☐ADD ☐ADHD ☐autism ☐brain injury	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's age and diagnosis.*
2. Is the requested medication prescribed by, or in consultation with, one of the following specialists? ☐pediatric neurologist ☐child/adolescent psychiatrist ☐child development pediatrician	☐Yes ☐No (prescriber's specialty: _____)
3. Has the beneficiary had a comprehensive evaluation by, or in conjunction with, the above specialist?	☐Yes – *Submit documentation of evaluation.* ☐No

Request for a Beneficiary 18 Years of Age and Older

1. What is the beneficiary's diagnosis?

☐ADD/ADHD
- ☐**Initial request** – *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).*
- ☐**Renewal request** – *Submit documentation supporting the continued need for the medication to manage symptoms.*

☐Narcolepsy – *Submit documentation of beneficiary's symptom history and results of an overnight sleep study (a PSG) AND a multiple sleep latency test (MSLT).*

☐Moderate to severe binge eating disorder (Vyvanse request)
- ☐**Initial request** – *Submit documentation of ALL of the following: an initial evaluation that shows a history of symptoms that meet the current DSM criteria; if the beneficiary does NOT have ADD/ADHD, the beneficiary has tried, or cannot try, SSRIs or topiramate, AND an offer of referral for cognitive behavioral therapy or other psychotherapy.*
- ☐**Renewal request** – *Submit documentation that the beneficiary experienced a reduction in binge eating.*

2. ***Stimulant requests***: Does the beneficiary have a history of or currently have substance use disorder [SUD] (drugs OR alcohol)?	☐Yes ☐No *Submit documentation of a recent eval. for current or past substance use.*
3. ***For a beneficiary with a history of or current SUD***, does the beneficiary have documentation of active participation in, or successful completion of, a substance use disorder treatment program?	☐Yes – *Submit documentation of treatment.* ☐No **---OR---** ☐not applicable
4. ***For a beneficiary with a history of or current SUD***, does the beneficiary have documentation of a recent urine drug screen (UDS) testing for licit (including fentanyl, oxycodone, tramadol, carisoprodol) and illicit drugs?	☐Yes – *Submit documentation of test results.* ☐No **---OR---** ☐not applicable

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

Prescriber Signature:	**Date**: