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 2/15/19*)

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		Non-Preferred Agents		
☐amphetamine mixed salts IR tablet (*Adderall*)	☐Focalin XR capsule	☐Adderall tablet	☐Dyanavel XR suspension	☐methylphenidate solution (*Methylin*)
☐Aptensio XR capsule	☐guanfacine ER tablet	☐Adderall XR capsule	☐Evekeo tablet	☐Mydayis ER capsule
☐atomoxetine capsule	☐methylphenidate IR tablet (Ritalin)	☐Adzenys ER suspension	☐Intuniv tablet	☐ProCentra solution
☐Daytrana patch	☐methylphenidate ER/SR tablet (*Ritalin-SR*)	☐Adzenys XR-ODT	☐Kapvay tablet	☐Relexxii ER tablet
☐dextroamphetamine ER cap		☐clonidine ER tablet (*Kapvay*)	☐methamphetamine tablet	☐Ritalin tablet
☐dextroamphetamine IR tablet (*Dexedrine IR*)	☐methylphenidate ER 24HR tab (*Concerta*)	☐Concerta tablet	☐Methylin solution	☐Ritalin LA capsule
☐dextroamphet/amphetamine mixed salts combo XR capsule (*Adderall XR*)	☐Quillichew ER tablet	☐Cotempla XR-ODT	☐methylphenidate chew (*Methylin*)	☐Strattera capsule
☐Focalin tablet	☐Quillivant XR suspension	☐Desoxyn tablet	☐methylphenidate CD capsule (*Metadate CD*)	☐Zenzedi tablet
	☐Vyvanse capsule	☐Dexedrine Spansule ER	☐methylphenidate ER capsule (*Ritalin LA*)	☐_____
	☐Vyvanse chewable tablet	☐dexmethylphenidate IR tablet (*Focalin*)	☐methylphenidate ER 72 mg tablet	
		☐dexmethylphenidate XR cap (*Focalin XR*)		
		☐dextroamphetamine sol'n (*ProCentra*)		

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: