

STIMULANTS AND RELATED AGENTS PRIOR AUTHORIZATION FORM (Form effective 1/1/20)

Prior authorization guidelines for **Stimulants and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

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|--------------------------------------|--|-----------------------|----------------------------|
| <input type="checkbox"/> New request | <input type="checkbox"/> 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

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|--|--|--|
| Drug requested: | Strength: | Dosage form (tablet, ODT, suspension, etc.): |
| Directions: | Quantity: | # months requested: |
| Diagnosis: | Diagnosis code (required): | |
| Has the beneficiary been taking the requested non-preferred medication within the past 90 days? | <input type="checkbox"/> Yes <i>Submit documentation of drug regimen and clinical response.</i> <input type="checkbox"/> No | |
| For a non-preferred drug: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class. | <input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No | |

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

- For a child < 4 years of age:**
 - Has a diagnosis of ADD or ADHD
 - Has a diagnosis of autism
 - Has a diagnosis of brain injury
 - Is prescribed the requested medication AND had a comprehensive evaluation by or in consultation with one of the following specialists:
 - pediatric neurologist
 - child/adolescent psychiatrist
 - child development pediatrician
- For a beneficiary ≥ 18 years of age:**
 - Has a diagnosis of ADHD consistent with current DSM criteria
 - Has a diagnosis of narcolepsy confirmed by an overnight PSG followed by an MSLT
 - For a diagnosis of binge eating disorder consistent with current DSM criteria:**
 - Tried and failed (or cannot try) SSRIs (unless beneficiary has comorbid ADD or ADHD)
 - Tried and failed (or cannot try) topiramate (unless beneficiary has comorbid ADD or ADHD)
 - Was referred for cognitive behavioral therapy or other psychotherapy
 - For a renewal request for treatment of binge eating disorder:**
 - experienced a reduction in binge eating since starting the requested medication
 - For a stimulant agent:**
 - Was assessed for potential risk of misuse, abuse, and/or addiction based on family and social history
 - Was educated regarding the potential adverse effects of stimulants, including risk of misuse, abuse, and addiction
 - Has documentation that the provider checked the PDMP for the beneficiary's controlled substance prescription history
 - For a beneficiary with a history of substance dependency, abuse, or diversion:**
 - Has results of a recent UDS for licit & illicit drugs with the potential for abuse that is consistent with prescribed controlled substances

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

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| Prescriber Signature: | Date: |
|------------------------------|--------------|

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