

7. The practitioner has ordered and reviewed a random urine drug screen at least every six (6) months. Yes No
Please provide the date of the most recent check: _____
8. The practitioner has regularly evaluated the patient for stimulant and/or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate health care provider, or referred the patient for evaluation for treatment if indicated. Yes No
9. *For Nonpreferred drugs, list pharmaceutical agents attempted and outcome:*

Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this patient.

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018.;