OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.***

Drug Requested: ***Stimulants/ADHD Medications*** **MEDICAID**

For Children less than FDA indicated Age and Adults over 18 years of age

Preferred stimulants/ADHD medications for individuals 6 yo to 18 yo do not require authorization.

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Name/Dosage Form: _____ **Strength:** _____

Dosing Schedule/Frequency: _____ **Length of Therapy:** _____

Quantity Requested: _____ **Total Daily Dose:** _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

CLINICAL CRITERIA: ***The following criteria MUST be met or authorization process will be delayed.***

Questions 1-7 must be answered for members < 18 years old. Questions 1 - 3 and 7 must be answered for adults.

1. Indicate the diagnoses being treated (include ALL ICD codes if applicable): _____
2. **Prescribing provider is a**: ❑**Psychiatri**st ❑ **Neurologist** ❑ **Developmental/Behavioral Pediatrician OR** ❑ **Pediatrician**?
   If Yes, check applicable box of the specialty prescriber. ❑ Yes ❑ No
   If No, has the provider consulted with a Psychiatrist, Neurologist, or a Developmental/Behavioral Pediatrician before prescribing the requested medication? ❑ Yes ❑ No
3. Did the primary care clinician use the *Diagnostic and Statistical Manual of Mental Disorders, 5TH Edition* and determined that criteria have been met (including documentation of impairment in more than 1 major setting) to make the diagnosis of ADHD? ❑Yes ❑No
4. Did the primary care clinician use evidence-based parent and/or teacher-administered behavior therapy as the first line of treatment? ❑ Yes ❑ No
5. Has the patient received a developmentally-appropriate, comprehensive ADHD assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented? ❑ Yes ❑ No
6. FDA indicated age:
   - Intuniv®: ≥ **4 years**
   - Immediate-release formulations (e.g., Ritalin®, Methylin® chewable tablet/solution, etc.: ≥ **3 years**
   - All other agents: ≥ **6 years**
7. ***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: ~~6/30/2017;~~ **8/31/2017**;