UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Attention Deficit Hyperactivity Disorder (ADHD) Stimulants

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Please select the requested stimulant exception category: (*Check all that apply*)

- ☐ Age Limit
- ☐ Use of three (3) or more stimulants
- ☐ Concurrent use of both methylphenidate and amphetamine drug class for under 18 years of age

Age Limit Exceeded Criteria for Approval: (*All* of the following criteria must be met)
(*Less than 4 years of age **or** less than 6 years of age for Adzenyx ER, Dyanavel XR, Desoxyn, Adhansia, Jornay PM, Contempla XR*)

1. Has the patient been diagnosed with Attention Deficit Hyperactivity Disorder? ❑ **Yes** ❑ **No**
2. Is the medication being prescribed by or in consultation with a child psychiatrist or mental health specialist who is qualified in the diagnosis and treatment of neuropsychiatric disease (certified, licensed scope of practice, etc.) with prescribing authority? ❑ **Yes** ❑ **No**
3. Has the prescriber submitted appropriate clinical rationale for ADHD stimulant use under Medicaid age limit? ❑ **Yes** ❑ **No**
   Rationale: _____

Use of three (3) or more ADHD stimulants Criteria for Approval: (*For all ages. Not required for combinations of the same product that differ only by strength*)

4. Has the patient been diagnosed with Attention Deficit Hyperactivity Disorder? ❑ **Yes** ❑ **No**
5. Has the provider submitted appropriate clinical rationale for using multiple stimulant agents? ❑ **Yes** ❑ **No**
   Rationale: _____

Concurrent use of both amphetamine and methylphenidate drug classes Criteria for Approval : *(For those under 18 years)*

6. Has the patient been diagnosed with Attention Deficit Hyperactivity Disorder? ❑ **Yes** ❑ **No**
7. Has the patient tried and failed a combination (IR and ER) within the same stimulant drug class for at least 4 weeks? ❑ **Yes** ❑ **No**

8. Has the provider submitted appropriate clinical rationale for concurrent use of both methylphenidate and amphetamine drug classes? ❑ **Yes** ❑ **No**
   Rationale: _____

Non-Preferred Product: (*Above criteria must also be met*)

9. Has the patient tried and failed at least one preferred agent within the same PDL class at an appropriate dose and duration, or has the prescriber submitted appropriate clinical rationale for prescribing the non-preferred product over a preferred option? ❑ **Yes** ❑ **No**
   Medication Name and Dose: _____
   Details of Failure: _____

Reauthorization Criteria:

1. Has the provider submitted an updated letter with medical justification or updated chart notes demonstrating positive clinical response? ❑ **Yes** ❑ **No**

Initial Authorization: Up to one (1) year
Reauthorization: Up to one (1) year

Note:

- Medicaid strongly encourages prescribers to follow the American Academy of Pediatrics (AAP) recommendation in using evidence-based Parent Training in Behavior Management (PTBM) and/or behavioral classroom interventions as first-line therapy, if available.

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date

For ADA accommodation or assistance completing this form, please call us at 801-538-6155.