



Fax Completed Form To
1.833.404.2392

Prescriber Help Desk
1.833.587.2012

Online
covermyeds.com/main/prior-authorization-forms/

Request for Prior Authorization CNS STIMULANTS AND ATOMOXETINE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Strength _____ Dosage Instructions _____ Quantity _____ Days Supply _____

Diagnosis:

Attention Deficit Hyperactivity Disorder (ADHD)

Did patient have inattentive or hyperactive/impulsive symptoms present prior to age 12? Yes No

Date of most recent clinical visit confirming improvement in symptoms from baseline: _____

Rating scale used to determine diagnosis: _____

Documentation of clinically significant impairment in two or more **current** environments (social, academic, or occupational).

Current Environment 1 & description: _____

Current Environment 2 & description: _____

Requests for short-acting agents:

Has dose of long-acting agent been optimized? Yes No

Adults: Provide medical necessity for the addition of a short-acting agent: _____

Children: Provide medical necessity for the need of more than one unit of a short-acting agent: _____

Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)

Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS)

Have non-pharmacological treatments been tried? No Yes *If Yes, please indicate below:*

Weight Loss

Position therapy

CPAP Date: _____

Maximum titration? Yes No

BiPAP Date: _____

Maximum titration? Yes No

Surgery Date: _____

Specifics: _____

Diagnosis confirmed by a sleep specialist? Yes No

Other (specify) _____

Prescriber review of patient's controlled substances use on the Iowa PMP website:

No Yes Date Reviewed: _____

Please document prior psychostimulant trial(s) and failures(s) including drug name(s) strength, dose, exact date ranges and failure reasons: _____

Other - Please provide all pertinent medication trial(s) relating to the diagnosis including drug name(s) strength, dose and exact date ranges: _____

Reason for use of Non-Preferred drug requiring approval: _____

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.