pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs – Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

STIMULANTS AND RELATED AGENTS PRIOR AUTHORIZATION FORM (*form effective 01/05/2021*)

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.

☐New request ☐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

Drug requested:	Strength:	Dosage form (tablet, ODT, suspension, etc.):	
Directions:		Quantity:	# months requested:
Diagnosis *(submit documentation)*:		Diagnosis code (*required*):	

INITIAL Requests

Has the beneficiary been taking the requested medication within the past 90 days?	☐Yes ☐No *Submit documentation of drug regimen and clinical response.*
For a non-preferred drug: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred drugs 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 drugs in this class.*	☐Yes ☐No *Submit documentation.*

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:
- ☐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:**
- ☐For the treatment of ADHD: ☐Has a diagnosis of ADHD that is consistent with current DSM criteria
- ☐For the treatment of narcolepsy: ☐Has a diagnosis of narcolepsy consistent with current International Classification of Sleep Disorders criteria (e.g., MSLT, overnight PSG, CSF hypocretin-1 concentration, clinical assessment)
- ☐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 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 the 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 (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

RENEWAL Requests

Has the beneficiary experienced a positive clinical response since starting the requested medication?	☐Yes ☐No *Submit documentation.*

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

Prescriber Signature:	Date: