

STIMULANTS AND RELATED AGENTS PRIOR AUTHORIZATION FORM (form effective 1/6/2025)

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.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html>.

| | | | | |
|---|------|--------------------------|------------------|--|
| <input type="checkbox"/> New request <input type="checkbox"/> Renewal request | | total # of pgs: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | | |
| Contact's phone number: | | NPI: | State license #: | |
| LTC facility contact/phone: | | Street address: | | |
| Beneficiary name: | | 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): | |
| Has the beneficiary been taking the requested medication within the past 90 days? | | <input type="checkbox"/> Yes <i>Submit documentation of drug regimen and clinical response.</i> <input type="checkbox"/> No | |

**Complete all sections that apply to the beneficiary and this request.
 Check all that apply and SUBMIT DOCUMENTATION for each item.**

INITIAL requests

1. For a NON-PREFERRED Stimulants and Related Agent:

Has a history of trial and failure of or a contraindication or an intolerance to the preferred Stimulants and Related Agents that are approved or medically accepted for treatment of the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)

2. For a beneficiary under 4 years of age:

Is prescribed the requested medication by or in consultation with 1 of the following specialists:

- pediatric neurologist
- child/adolescent psychiatrist
- child development pediatrician

Had a comprehensive evaluation by or in consultation with 1 of the following specialists:

- pediatric neurologist
- child/adolescent psychiatrist
- child development pediatrician

3. For a beneficiary 18 years of age or older: (CHECK ALL THAT APPLY)

- For the treatment of ADHD:**
 - Has a diagnosis of ADHD that is consistent with current DSM criteria
- 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
- For stimulant agent for a beneficiary with a history of comorbid substance dependency, abuse, or diversion:**
 - Has results of a recent UDS testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances
- For the treatment of moderate to severe binge eating disorder:**
 - Has a diagnosis of binge eating disorder that is consistent with current DSM criteria
 - Has comorbid ADD or ADHD
 - Does not have ADD or ADHD and 1 of the following:
 - Tried and failed (or cannot try) SSRIs
 - Tried and failed (or cannot try) topiramate
 - Was referred for cognitive behavioral therapy or other psychotherapy
- For the treatment of narcolepsy:**
 - Has a diagnosis of narcolepsy that is consistent with current International Classification of Sleep Disorders criteria (e.g., MSLT, overnight PSG, CSF hypocretin-1 concentration, clinical assessment)

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 866-240-3712

Prescriber Signature:

Date:

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