Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Stimulants (ADHD) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Stimulants (ADHD).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

Preferred stimulants/ADHD medications for individuals 4 to 17 years of age do not require Prior Authorization.

Stimulants prescribed for children under the age of four (4) must be prescribed by pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists.

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

1. Please indicate diagnosis per the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition:

   □ ADHD – Inattentive Predominant □ ADHD – Hyperactive/Impulsive Predominant □ ADHD - Combined

6 – Clinical Criteria

2. Patient Age Category:
   □ ≤ 4 years old □ ≥ 18 years old

3. Has the provider reviewed the Virginia Prescription Monitoring Program? (Every 3 months during therapy)
   □ No □ Yes
   Date of Last Review: _____
   Date of Last Opioid Rx: _____
   Date of Last Benzodiazepine Rx: _____

4. Has the provider ordered and reviewed a urine drug screen in the past 30 days? (Every 6 months during therapy)
   □ No □ Yes
   Date of Last Urine Drug Screen: _____
   (please attach copy)

5. Has the provider evaluated the patient for stimulant and/or substance use disorder, and, if present initiated specific treatment, consulted with an appropriate healthcare provider, or referred the patient for evaluation for treatment if indicated?
   □ No □ Yes

6. For non-preferred stimulants/ADHD medications, list pharmaceutical agents attempted and outcome:

   _____

7. Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this member:

   _____

7 – Provider Sign-Off

Additional Information – Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**