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:** Pharmacy | Community Provider Portal | Kaiser Permanente

- 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. Is this request for initial or renewal of a prior therapy?
   ☐ Initial request ☐ Renewal request

For Initial request, complete the rest of the sections below. If therapy is approved, length of approval is 1 year.

For renewal request, complete the following question to receive a 12-month approval, and sign the form.

2. The practitioner has regularly evaluated the member for stimulant or other substance use disorder and, if present, initiated specific treatment, consulted with an appropriate health care provider, and referred the member for evaluation for treatment if indicated.

   ☐ **YES** ☐ **NO**

6 – Clinical Criteria

If the child is under 4 and you are prescribing a stimulant:

1. Are you a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists?
   □ No □ Yes

Stimulants/ADHD medications for adults over 18:

2. Does the member have documentation of a diagnosis of ADHD according to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (including documentation of impairment in more than one major setting), determined by the primary care clinician?
   □ No □ Yes

3. 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

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

   _____

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

   _____

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**

_____

_____

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

Provider Signature:	**Date:**