



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Attention Deficit-Hyperactive (ADHD) & Narcolepsy
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Attention Deficit-Hyperactive (ADHD) & Narcolepsy**. Please complete all sections, incomplete forms will delay processing. 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 all sections are complete.

KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

Medications:

<ul style="list-style-type: none">• COTEMPLA XR-ODT TBED (6 to 17 years)• DAYTRANA PTCH (6 to 17 years)• QUILLICHEW ER CHER (≥6 years)• QUILLIVANT XR SRER (≥6 years)	<ul style="list-style-type: none">• AZSTARYS CAPS (≥6 years)• JORNAY PM CP24 (≥6 years)• RELEXXII TBCR (≥6 years)
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1 – Patient Information

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

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____ Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
 Yes – please provide your provider referral number here: _____

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/Clinical Criteria

1. Is this request for initial or continuing therapy?
 Initial therapy Continuing therapy, State date: _____
2. Indicate the patient’s diagnosis for the requested medication: _____

Clinical Criteria:

1. Indicate the member’s age: _____.
2. **AND** member has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) as confirmed by psychoeducational testing***,
 No Yes
3. **AND** member has had an adequate trial* (1 week) and/or intolerance** or allergy to dextroamphetamine-amphetamine (generic Adderall XR), intermediate or long-acting methylphenidate (methylphenidate SR, methylphenidate CD, or methylphenidate ER), and dexamethylphenidate (generic Focalin XR)?
 No Yes

For continuation of therapy, please respond to additional questions below:

1. Has the member continued to meet the initial review criteria and has demonstrated positive clinical response to medication?
 No Yes

NOTES:

**Adequate trial of a long-acting agent is further defined as wearing off that is not resolved by increasing the dose, AND adding a short-acting agent OR increasing frequency to twice daily OR clinically significant side effects related to the dosage form that cannot be resolved by adjusting the dose or timing*

***Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment and do not require medication discontinuation*

****Criteria only applies for 18 years of age and older*

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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

Prescriber Signature:	Date:
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Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility