UnitedHealthcare Community Plan

ADHD Products – New York EPP
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD) □ Binge eating disorder (BED) □ Fatigue associated with medical illness in palliative or end of life care □ Fatigue associated with multiple sclerosis □ Mental fatigue secondary to traumatic brain injury (e.g. post-concussion syndrome) □ Narcolepsy
□ **Yes** □ **No**	**Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?**
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any preferred alternatives for the given diagnosis?** *(If yes, complete Section D above)*
	LESS THAN THE FDA APPROVED MINIMUM AGE
□ **Yes** □ **No**	**Is the patient unresponsive to, or has had an inadequate response to behavioral therapy?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is the patient experiencing moderate-severe continuing disturbance in function despite behavioral therapy?**
	MULTI-SOURCE BRAND MEDICATION REQUESTS
□ **Yes** □ **No**	**Does the patient meet any of the following circumstances?** *(If yes, check which applies)* □ The multi-source brand is being requested because of an adverse reaction, allergy or sensitivity to a generic equivalent □ The multi-source brand is being requested due to a therapeutic failure with the generic equivalent □ The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient □ Special clinical circumstances exist that preclude the use of a generic version of the multi-source brand medication for the patient
	KAPVAY / CLONIDINE ER
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* □ Guanfacine ER (generic Intuniv) □ Atomoxetine (generic Strattera)
	VYVANSE (NEW & CONTINUATION REQUESTS)
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any of the following?** *(If yes, check all that apply and complete Section D above)* □ BRAND Adderall XR (amphetamine/dextroamphetamine salts extended-release) □ Methylphenidate extended-release tablet or capsule (generic Concerta or Metadate CD)
□ **Yes** □ **No**	**Does the patient have a history of or potential for a substance abuse disorder?**
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to atomoxetine (Strattera)?**
	CONTINUATION OF THERAPY - VYVANSE
□ **Yes** □ **No**	**Is there rationale for needing to continue the patient on Vyvanse therapy?** *If yes, please provide rationale:*
□ **Yes** □ **No**	**Is there documentation of positive clinical response to Vyvanse therapy?**

Provider Signature: _____ **Date:** _____