UnitedHealthcare Community Plan

Stimulants and Related Agents - Pennsylvania
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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

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

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ Yes □ No	**If the requested medication is non-preferred, does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred Stimulants and Related Agents approved or medically accepted for the patient's diagnosis?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**If the requested medication is non-preferred, does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred Stimulants and Related Agent?**
□ Yes □ No	**Does the patient have a diagnosis of ADHD as documented by a history consistent with the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria?**
□ Yes □ No	**Does the patient have a diagnosis of narcolepsy, confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders)?**
□ Yes □ No	**Does the patient have a diagnosis of moderate to severe binge eating disorder with any of the following?** *(If yes, check which applies)* □ Diagnosis documented by a history that is consistent with the current DSM criteria □ Documented history of therapeutic failure, contraindication, or intolerance to selective serotonin reuptake inhibitors or topiramate *(Complete "Previous Medication Trials/Contraindications" section on first page)* □ Documentation of a referral for cognitive behavioral therapy or other psychotherapy
□ Yes □ No	**Was the patient assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescribing provider**?
□ Yes □ No	**Is there documentation that the patient has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction?**
□ Yes □ No	**Is there documentation that the prescriber or prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program for the patient's controlled substance prescription history?**
□ Yes □ No	**Does the patient have a history of comorbid substance dependency, abuse, or diversion?**
□ Yes □ No	**If yes to the above question, does the patient have results of a recent urine drug screen 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?**
CONTINUATION OF THERAPY	
□ Yes □ No	**Is there documentation of tolerability and a positive clinical response to the medication?**
CHILDREN UNDER 4 YEARS OF AGE	
□ Yes □ No	**Is the requested medication prescribed by or in consultation with one of the following?** *(If yes, check which applies)* □ Pediatric neurologist □ Child and adolescent psychiatrist □ Child development pediatrician
□ Yes □ No	**Is there chart-documented evidence of a comprehensive evaluation by or in consultation with a specialist listed above?**
PROVIGIL / MODAFINIL / NUVIGIL / ARMODAFINIL *(cont'd on the next page)*	
□ Yes □ No	**Is the patient receiving concurrent treatment with sedative hypnotics?**
□ Yes □ No	**If the requested medication is non-preferred, does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred analeptic (e.g., armodafinil, modafinil, etc.) Stimulants and Related Agents approved or medically accepted for the patient's diagnosis?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a diagnosis of narcolepsy and shift work sleep disorder, confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders)?**

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□ **Yes** □ **No**	**Does the patient have obstructive sleep apnea/hypopnea syndrome (OSAHS) with any of the following?** *(If yes, check which applies)* □ Diagnosis of OSAHS was confirmed according to the most recent consensus treatment guidelines (e.g., American Academy of Sleep Medicine International Classification of Sleep Disorders) □ A history of therapeutic failure of continuous positive airway pressure (CPAP) to resolve excessive daytime sleepiness [documented by either Epworth Sleepiness Scale greater than 10 or multiple sleep latency test (MSLT) less than 8 minutes] with documented compliance to CPAP treatment □ The patient has a medical reason CPAP cannot be used, and has therapeutic failure of an oral appliance for OSAHS
□ **Yes** □ **No**	**Does the patient have multiple sclerosis-related fatigue with one of the following?** *(If yes, check which applies)* □ The patient is receiving treatment for multiple sclerosis □ The patient is not being treated, and the medical record documents the rationale for the patient not being treated
THERAPEUTIC DUPLICATION - DRUG UTILIZATION REVIEW	
□ **Yes** □ **No**	**Is the patient being transitioned to another Stimulants and Related Agent with the same duration of action (i.e., short-acting or long-acting) with the intent of discontinuing one of the medications?**
□ **Yes** □ **No**	**Is there supporting peer-reviewed literature or national treatment guidelines that corroborate concomitant use of the medications being requested?** *If yes, please specify:*

Provider Signature: _____ Date: _____