UnitedHealthcare Community Plan

Stimulants/ADHD Medications – Virginia
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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Patient First name:	Patient Last name:	Patient DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)?**
□ Yes □ No	**Did the primary care clinician use the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition to determine that criteria have been met (including documentation of impairment in more than 1 major setting) to make the diagnosis of ADHD?**
□ Yes □ No	**Has the prescriber reviewed the Virginia Prescription Monitoring Program (PMP) on the date of this request?**
□ Yes □ No	**Has the prescriber ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant (within 30 days of this request) and attached/submitted a copy of the most recent UDS (the urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates)?** *(If yes, DOCUMENTATION IS REQUIRED)*
□ Yes □ No	**For non-preferred medications, has the patient had therapeutic failure of at least two preferred drugs within the same class as appropriate for diagnosis unless otherwise noted in the clinical criteria?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
FOR CHILDREN UNDER AGE OF 4	
□ Yes □ No	**Is the prescriber a psychiatrist, neurologist, developmental/behavioral pediatrician or pediatrician who has consulted one before prescribing the requested medication?**
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the practitioner checked the Prescription Monitoring Program at least every three months after the initiation of treatment?** *If yes, provide the date of the most recent check:*
□ Yes □ No	**Has the practitioner ordered and reviewed a random urine drug screen (UDS) at least every six months?** *If yes, provide the date of the most recent UDS:*
□ Yes □ No	**Has the practitioner regularly evaluated the patient for stimulant and/or other substance use disorder?**
□ Yes □ No	**Is stimulant and/or other substance use disorder present?**
□ Yes □ No □ Not applicable	**If yes to the above, has the practitioner initiated specific treatment, consulted with an appropriate health care provider, or referred the patient for evaluation for treatment if indicated?**

Provider Signature: _____ **Date:** _____