

## ADHD Products - Arizona Prior Authorization Request Form

Please complete this <u>entire</u> 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.

Last Name:   Last Name:   M.D./D.O.	Section A – Member Infor	mation						
City:   State:   ZIP Code:	First Name:		Last Name	:		Memb	er ID:	
Primary Insurance Information (if any):  Is the requested medication:   New or   Continuation of Therapy? If continuation, list start date:	Address:							
Primary Insurance Information (if any):  Is the requested medication:   New or   Continuation of Therapy? If continuation, list start date:	City:		State:			ZIP Co	ode:	
Is the requested medication:	Phone:		DOB:		Allergies:			
Is this patient currently hospitalized?	Primary Insurance Information	ı (if any):				1		
Section B - Provider Information First Name:  Last Name:  M.D./D.O.  Address:  Phone:  Phone:  Fax:  Office Contact Name / Fax attention to:  Section C - Medical Information  Medication:  Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  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	Is the requested medicati	ion: □ New or □	Continuat	ion of Thera	apy? If continuation,	list sta	rt date:	_
First Name:    Last Name:   City:   State:   ZIP code:	Is this patient currently h	ospitalized?	Yes 🗆 No	If recently	discharged, list disc	harge o	date:	
Address:    City:   State:   ZIP code:		mation						
Phone:						1_		
Office Contact Name / Fax attention to:  Section C - Medical Information  Medication:  Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant?				_				ZIP code:
Section C - Medical Information  Medication:  Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  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	Phone:	Fax:		NPI #:		Specia	ılty:	
Medication:  Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant?	Office Contact Name / Fax atte	ention to:						
Directions for use:  Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant?		nation						
Diagnosis (Please be specific & provide as much information as possible):  Is this member pregnant?	Medication:						Strength:	
Is this member pregnant?	Directions for use:						Quantity:	
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	Diagnosis (Please be specific	& provide as muc	:h information	n as possible)	:		ICD-10 C	ODE:
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			If yes,	what is this	member's due date? _			
Medication Name Strength Directions Dates of Therapy discontinuation    Dates of Therapy   discontinuation							Reasor	o for failure /
	Medication Name	Strength	Dire	ections	Dates of Therap	У		
	Section E - Additional infe	ormation and F	xplanation	of why pref	erred medications we	ould no	t meet the	e natient's needs:
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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 a history of failure, contraindication, or intolerance to a trial of at least three preferred products? (If yes, complete Section D above)							
	N	MEMBERS LESS THAN 6 YEARS OF AG	SE .					
□ Yes □ No	Does the patient have a diagnosis of attention deficit hyperactivity disorder (ADHD)?							
□ Yes □ No	Have psychosocial issue	es been evaluated before request for A	DHD medications?					
□ Yes □ No	Have non-medication alt If yes, list non-medication	ernatives been attempted before reque alternatives and dates:	est for ADHD medications?					
□ Yes □ No	-	exceeding the FDA maximum dose?	on (FDA) maximum daily dose, is there					
Provider Sig	nnature•		Date:					

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