UnitedHealthcare Community Plan

ADHD Products - Ohio
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) □ Narcolepsy □ Mental fatigue secondary to traumatic brain injury (e.g. post-concussion syndrome) □ Fatigue associated with medical illness in patients in palliative or end of life care
□ Yes □ No	**Is the patient currently on the requested drug?** *If yes, list start date:*
□ Yes □ No	**Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?** *If yes, list start date and discharge date:*
□ Yes □ No	**Does the patient meet one of the following circumstances?** *(If yes, check which applies)* □ The brand is being requested because of an adverse reaction, allergy or sensitivity to a generic equivalent □ The brand is being requested due to a therapeutic failure with the generic equivalent □ The 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 brand medication for the patient □ The generic is being requested because of an adverse reaction, allergy or sensitivity to brand equivalent □ The generic is being requested due to a therapeutic failure with the brand equivalent □ The generic is being requested because transition to a brand equivalent could result in destabilization of the patient □ Special clinical circumstances exist that preclude the use of the brand version of the generic medication for the patient
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to any preferred alternatives?** *(If yes, complete Section D above)*

KAPVAY

□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to both of the following?** *(If yes, complete Section D above)* □ Guanfacine ER (generic Intuniv) □ Atomoxetine (generic Strattera)

LESS THAN THE FDA APPROVED MINIMUM AGE

□ Yes □ No	**Was the child unresponsive to, or has had an inadequate response to parent- and/or teacher-administered behavioral therapy?** *If yes, describe therapy and reason for discontinuation:*
□ Yes □ No	**Is the child experiencing moderate-severe continuing disturbance in function despite behavioral therapy?**

EXCEED QUANTITY LIMIT

□ Yes □ No	**Is there a reason or special circumstance that the patient requires a greater quantity of medication?** *If yes, list reasoning:*

Provider Signature: _____ **Date:** _____