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.

Section A – Patient Information

First Name:	Last Name:	Patient 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 patient pregnant? □ Yes □ No **If yes, what is this patient'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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Patient First name:	Patient Last name:	Patient DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have 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 a copy of the most recent UDS?** *(If yes, DOCUMENTATION REQUIRED)*
□ Yes □ No	**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 Section D above)*
FOR CHILDREN UNDER AGE OF 4	
□ Yes □ No	**Is the prescribing provider a psychiatrist, neurologist, developmental/behavioral pediatrician, or pediatrician, or has the provider consulted one before prescribing the requested medication?** *If yes, list specialty:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the prescriber checked the Prescription Monitoring Program at least every three months after the initiation of treatment and has provided the date of the most recent check?** *If yes, list date of most recent check:*
□ Yes □ No	**Has the prescriber ordered and reviewed a random urine drug screen at least every six months and has provided the date of the most recent check?** *If yes, list date of most recent check:*
□ Yes □ No	**Has the prescriber regularly evaluated the patient for stimulant and/or other substance use disorder?**
□ Yes □ No	**Is stimulant and/or other substance use disorder present?** *If yes, list type of use disorder present:*
□ Yes □ No	**Has the prescriber initiated specific treatment, consulted with an appropriate health care provider, or referred the patient for evaluation for treatment if indicated?**

Provider Signature: _____ Date: _____