

## ADHD and Anti-Narcolepsy Products - Washington 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: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://www.uhcprovider.com) for a list of preferred alternatives

## ADHD and Anti-Narcolepsy Products - Washington Prior Authorization Request Form

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
<b>Clinical and Drug Specific Information</b>		
<b>ALL REQUESTS</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the requested medication being used for ADHD?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, contraindication or intolerance to all short acting and long acting stimulants (both preferred and non-preferred) FDA indicated for ADHD?</b> <i>(If yes, complete Section D above)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, contraindication or intolerance to at least two alternatives?</b> <i>(If yes, complete Section D above)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the following apply to the patient?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Trial of two preferred products, other than the generic equivalent to the requested brand <input type="checkbox"/> Trial of the generic equivalent of the product being requested from 5 manufacturers. <i>(If fewer than 5 manufacturers, must try all manufacturers)</i>	
	<b>Is the request for combined use of alpha agonists?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Intuniv (guanfacine) <input type="checkbox"/> Tenex (guanfacine) <input type="checkbox"/> Kapvay (clonidine SR) tabs <input type="checkbox"/> Catapres (clonidine) tabs <input type="checkbox"/> Catapres (clonidine) patch	
<b>MODAFINIL/ARMODAFINIL FOR PATIENT UNDER THE AGE OF 18</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have one of the following diagnosis?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Mental health condition (such as ADHD, depression, schizophrenia, bipolar disorder) <input type="checkbox"/> Non-mental health condition (such as narcolepsy, shift work sleep disorder, sleep apnea, multiple sclerosis)	
<b>MENTAL HEALTH POLYPHARMACY</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient taking five or more psychotropic/mental health medications?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Will the patient remain on five or more psychotropic/mental health medications or is the patient titrating/changing medications and will be on less than five psychotropic/mental health medications?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Transitioning medications AND will be on LESS THAN five psychotropic medications <i>List drugs that will be stopped and dates they will be stopped:</i>  <input type="checkbox"/> Patient will remain on five or more psychotropic medications	
<b>CONTINUATION OF THERAPY</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there documentation of positive clinical response to treatment?</b> <i>If yes, list response:</i>	

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.