UnitedHealthcare Community Plan

Stimulants and Related Agents - Pennsylvania
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 a history of therapeutic failure, contraindication, or intolerance of the preferred stimulants and related agents?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred stimulants and related agent?**
□ **Yes** □ **No**	**Does the patient have a diagnosis of ADHD as documented by a history consistent with the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria?**
□ **Yes** □ **No**	**When prescribed for a diagnosis of narcolepsy, has the diagnosis been confirmed by an overnight PSG (polysomnogram) followed by a MSLT (Multiple Sleep Latency Test)?**
□ **Yes** □ **No**	**Does the patient have moderate to severe binge eating disorder?**
□ **Yes** □ **No**	**Was the patient assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescribing provider**?
□ **Yes** □ **No**	**Is there documentation that the patient has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction?**
□ **Yes** □ **No**	**Is there documentation that the prescriber or prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program for the patient's controlled substance prescription history?**
□ **Yes** □ **No**	**For a patient with a history of comorbid substance dependency, abuse, or diversion, does the patient have results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, tramadol, and carisoprodol) that is consistent with prescribed controlled substances?**
CHILDREN UNDER 4 YEARS OF AGE	
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Attention deficit hyperactivity disorder (ADHD) □ Attention deficit disorder (ADD) □ Brain injury □ Autism
□ **Yes** □ **No**	**Is the patient being prescribed the medication by or in consultation with one of the following?** *(If yes, check which applies)* □ Pediatric neurologist □ Child and adolescent psychiatrist □ Child development pediatrician
□ **Yes** □ **No**	**Does the patient have chart-documented evidence of a comprehensive evaluation by or in consultation with a specialist listed above?**
PROVIGIL / MODAFINIL / NUVIGIL / ARMODAFINIL *(cont'd on the next page)*	
□ **Yes** □ **No**	**Does the patient have narcolepsy confirmed by an overnight polysomnogram (PSG) followed by a multiple sleep latency test (MSLT)?**
□ **Yes** □ **No**	**Does the patient have obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by any of the following?** *(If yes, check which applies)* □ An overnight PSG with a respiratory disturbance index of greater than 5 per hour □ Therapeutic failure of continuous positive airway pressure (CPAP) to resolve excessive daytime sleepiness (documented by either Epworth Sleepiness Scale greater than 10 or MSLT less than 6 minutes) with documented compliance to CPAP treatment or, if patient has a medical reason CPAP cannot be used, therapeutic failure of an oral appliance for OSAHS
□ **Yes** □ **No**	**Does the patient have shift work sleep disorder as documented by any of the following?** *(If yes, check which applies)* □ The patient's recurring work schedule for one (1) month or longer □ Shift work that results in sleepiness on the job or insomnia at home that interferes with activities of daily living

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Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Does the patient have multiple sclerosis-related fatigue with any of the following?** *(If yes, check which applies)* □ Is receiving treatment for multiple sclerosis or, if not being treated, the medical record documents the rationale for the patient not being treated □ Has a history of therapeutic failure, contraindication, or intolerance to methylphenidate at maximum tolerated doses *(Complete Section D above)*
MODERATE TO SEVERE BINGE EATING DISORDER - VYVANSE	
□ Yes □ No	**Does the patient have a diagnosis documented by a history that is consistent with the current DSM criteria?**
□ Yes □ No	**Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to selective serotonin reuptake inhibitors or topiramate?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have documentation of a referral for cognitive behavioral therapy or other psychotherapy?**
CONTINUATION OF THERAPY - MODERATE TO SEVERE BINGE EATING DISORDER - VYVANSE	
□ Yes □ No	**Is there documentation of a reduction in binge eating?**

Provider Signature: _____ **Date:** _____