

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
ADD/ADHD/NARCOLEPSY AGENTS

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
 Member ID #: _____ Patient Name: _____ DOB: _____
 Patient Address: _____
 Provider NPI: _____ Prescriber Name: _____ Phone: _____
 Prescriber Address: _____ Fax: _____
 Pharmacy Name: _____ Address: _____ Phone: _____
Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.
 Pharmacy
 NPI: _____ Pharmacy Fax: _____ NDC : _____

Prior Authorization (PA) is required for ADD/ADHD/Narcolepsy Agents for patients 21 years of age or older. PA is also required for all non-preferred agents, regardless of age, the first day of therapy. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. *If a non-preferred long-acting medication is requested, a trial of the preferred immediate release and extended release product of the same chemical entity is required, unless evidence is provided that use of these products would be medically contraindicated.

Preferred

- Adderall XR
- Amphetamine Salt Combo
- Concerta
- Daytrana
- Dexedrine Caps
- Dextroamphetamine Tabs
- Focalin
- Focalin XR

- Methylin
- Methylin ER
- Methylphenidate
- Methylphenidate ER
- Methylphenidate SR
- Provigil
- Strattera
- Vyvanse

Non-Preferred

- Adderall Amphetamine ER*
- Desoxyn Metadate CD*
- Dexmethylphenidate Metadate ER*
- Methylin Chew Ritalin LA*
- Methylin Solution Ritalin SR*
- Nuvigil
- Ritalin

Strength _____ Dosage Instructions _____ Quantity _____ Days Supply _____

Diagnosis:

- Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG) Other (specify) _____ (see below)*

Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS)
 Have non-pharmacological treatments been tried? No Yes If Yes, please indicate below:
 Weight Loss Position therapy
 CPAP Date: _____ Maximum titration? Yes No
 BiPAP Date: _____ Maximum titration? Yes No
 Surgery Date: _____ Specifics: _____

Date of Diagnosis: _____ Date of most recent mental status exam: _____ Test used for diagnosis: _____

Please document prior psychostimulant trial(s) and failures(s) including drug name(s) strength, dose, exact date ranges and failure reasons: _____

Other - Please provide all pertinent medication trial(s) relating to the diagnosis including drug name(s) strength, dose and exact date ranges: _____

Reason for use of Non-Preferred drug requiring approval: _____

Prescriber Signature: _____ Date of Submission: _____
MUST MATCH PRESCRIBER LISTED ABOVE

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.