HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

STIMULANTS AND RELATED AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

Prior authorization guidelines for **Stimulants and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form (tablet, ODT, suspension, etc.):	
Directions:		Quantity:	# months requested:
Diagnosis *(submit documentation)*:		Diagnosis code (*required*):	
Has the beneficiary been taking the requested medication within the past 90 days?		☐Yes ☐No	*Submit documentation of drug regimen and clinical response.*

Complete all sections that apply to the beneficiary and this request.

Check all that apply and SUBMIT DOCUMENTATION for each item.

INITIAL requests

1. **For a NON-PREFERRED Stimulants and Related Agent:**
   ☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred Stimulants and Related Agents that are approved or medically accepted for treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
2. **For a beneficiary under 4 years of age:**
   ☐Is prescribed the requested medication by or in consultation with 1 of the following specialists:
   - ☐pediatric neurologist
   - ☐child/adolescent psychiatrist
   - ☐child development pediatrician

   ☐Had a comprehensive evaluation by or in consultation with 1 of the following specialists:
   - ☐pediatric neurologist
   - ☐child/adolescent psychiatrist

☐ child development pediatrician

3. For a beneficiary 18 years of age or older:

☐ **For the treatment of ADHD:**
- ☐ Has a diagnosis of ADHD that is consistent with current DSM criteria

☐ **For the treatment of moderate to severe binge eating disorder:**
- ☐ Has a diagnosis of binge eating disorder that is consistent with current DSM criteria
- ☐ Has comorbid ADD or ADHD
- ☐ Does not have ADD or ADHD and 1 of the following:
  - ☐ Tried and failed (or cannot try) SSRIs
  - ☐ Tried and failed (or cannot try) topiramate
- ☐ Was referred for cognitive behavioral therapy or other psychotherapy

☐ **For the treatment of narcolepsy:**
- ☐ Has a diagnosis of narcolepsy that is consistent with current International Classification of Sleep Disorders criteria (e.g., MSLT, overnight PSG, CSF hypocretin-1 concentration, clinical assessment)

☐ **For a stimulant agent:**
- ☐ Was assessed for potential risk of misuse, abuse, and/or addiction based on family and social history
- ☐ Was educated regarding the potential adverse effects of stimulants, including the risk of misuse, abuse, and addiction

☐ **For stimulant agent for a beneficiary with a history of comorbid substance dependency, abuse, or diversion:**
- ☐ Has results of a recent UDS testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

RENEWAL requests	
Has the beneficiary experienced a positive clinical response since starting the requested medication?	☐ Yes ☐ No *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: