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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

FOR STIMULANTS/ADHD MEDICATIONS FOR CHILDREN LESS THAN FDA INDICATED AGE AND ADULTS OVER 18

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

Preferred stimulants/ADHD medications for individuals 4 to 17 years of age do not require Service Authorization. Member must meet the minimum FDA-approved age.

If your request is for a non-preferred non-stimulant, please go to question 4 and submit form.

Stimulants prescribed for children under the age of four (4) must be prescribed by pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists.

MEMBER INFORMATION

Last Name: _____ **First Name:** _____

Medicaid ID Number: _____ **Date of Birth:** _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____ **First Name:** _____

NPI Number: _____

Phone Number: _____ **Fax Number:** _____

If the child is under 4 and you are prescribing a stimulant:

Are you a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists?

☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

DIAGNOSIS AND MEDICAL INFORMATION

Stimulants/ADHD medications for adults over 18 – to receive an approval for this drug, complete the following questions. This does not apply to non-stimulant ADHD medications (such as atomoxetine, clonidine ER, Kapvay®, guanfacine ER, Intuniv®, Qelbree®, etc.).

Does the member meet the following criteria?

1. Indicate the diagnoses being treated (include all ICD codes if applicable):

   _____

2. Did the primary care clinician use the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition and determine that criteria have been met (including documentation of impairment in more than 1 major setting) to make the diagnosis of ADHD?

   ☐ Yes ☐ No

Does the member meet the following criteria for the maintenance request?

3. The practitioner has regularly evaluated the member for stimulant or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate health care provider, or referred the member for evaluation for treatment if indicated.

   ☐ Yes ☐ No

To request a non-preferred agent, please answer the questions below, providing all requested information.

4. For non-preferred stimulants/ADHD medications, list pharmaceutical agents attempted and outcome:

   _____

5. Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this member.

   _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811