

ADD/ADHD Agents Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information

2. Physician information

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

			Specify:
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7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Yes No Does the patient have a history of substance abuse in the last 365 days?

If the patient is greater than or equal to 19 years of age, please also answer the following questions:

Yes No Does the patient have a diagnosis of ADD/ADHD in the past 730 days?

Yes No Does the patient have a diagnosis of narcolepsy in the past 730 days?

Yes No Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.

Yes No Patient has a documented allergy or contraindication to preferred agents in this class.

Yes No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For atomoxetine:

Yes No Does the client have a diagnosis of bipolar disorder in the last 365 days?

Yes No Does the client have a diagnosis of suicidal ideation or suicide attempt in the last 180 days?

Yes No Does the client have a diagnosis of hepatic impairment in the last 180 days?

Yes No Does the client have a history of severe cardiovascular disease in the last 365 days?

Yes No Does the client have a diagnosis of pheochromocytoma or narrow angle glaucoma in the last 365 days?

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Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

For the Texas Medicaid Preferred Drug List, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/formulary-search>

9. Physician signature

Prescriber or authorized signature

Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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