

If the following information is not complete, correct, and legible, the SA process could be delayed. Please use one form per member.

Preferred stimulants/ADHD medications for individuals 4 to 17 years old do not require Service Authorization.

If your request is for a non-preferred non-stimulant, please go to question 8 and submit form.

Stimulants prescribed for children under the age of 4 must be prescribed by a 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:												
Gender: 🗌 Male 🗌 Female	Weight in Kilograms:												
PRESCRIBER INFORMATION													
Last Name:	First Name:												
NPI Number:													
Phone Number:	Fax Number:												

If the member is under the age of 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.)

MCC M4 SA Form: Stimulants/ADHD Medications for Children under 4 and Adults 18 and Older

Member's Last Name:									Member's First Name:													
DF	NUG I	NFOR	ΜΑΤ	ION																		
Dr	ug Na	me/Fo	orm:																			
Str	ength	า:																				
Do	sing F	Freque	ency:																			
Lei	ngth c	of Thei	rapy:																			
Qu	antit	y per [Day:																			
DI	AGN(DSIS A	ND I	MEDI	CAL	INFO	ORM	ΙΑΤΙ	ON													
fol Str	lowin atter	nts/AE ng ques a®, clo	stion nidir	s. This ne ER,	s doe Kap	es no vay®	t app , gua	ply to anfac	o no cine	n-stiı ER, Ir	mu	lant	ADH									
Do	estn	e mem	iber	meet	tne		wing	crite	eria?													
1.	Indic	cate th	e dia	gnose	s be	ing t	reate	ed (ir	ncluc	le all	ICE) coc	les, if	appl	icab	le):						
2.	 Did the primary care clinician use the <i>Diagnostic and Statistical Manual of Mental Disorders, 5th Edition</i> 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 																					
3.	Has requ	the pre lest?	escrit	per rev	view	ed th	ne Vi	rgini	a Pre	escrip	otio	n M	onito	ring F	rog	ram	(PMP)	on tł	าe dat	e of t:	this	
See: VIRGINIA PRESCRIPTION MONITORING PROGRAM (PMP) https://www.dhp.virginia.gov/dhp_programs/pmp/																						
	□ Y	′es		🗌 No)																	
4.	requ urine	prescr lested e drug , and o	stim scree	ulant v ens M	with UST	in 30 chec	days k for	s of t [.] ben	his r	eque	est a	and a	а сору	of t	he n	nost	recen	t UDS	is att	acheo	d. (Th	e
	Y	′es		🗌 No)																	
(Fc	orm co	ontinue	ed on	next	page	e.)																

MCC M4 SA Form: Stimulants/ADHD Medications for Children under 4 and Adults 18 and Older

Member's Last Name:								Member's First Name:										
Do	es the member	r meet th	e follow	ving crit	teria f	or the	e maint	enance	requ	est?	11					<u> </u>	<u> </u>]	
5.	Has the practitioner checked the Prescription Monitoring Program at least every three months after the initiation of treatment?														e			
	Please provide	e the date	e of the r	nost re	ecent o	check	:											
6.	Has the practi	s the practitioner ordered and reviewed a random urine drug screen at least every six m] Yes No											mon	ths?				
	Please provide	e the date	e of the r	nost re	ecent o	check	:											
7.	Has the practitioner regularly evaluated the member for stimulant and/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														r,			
То	request a Non	-Preferre	d agent,	please	e answ	ver th	e quest	tion bel	ow, g	iving	all re	ques	sted	infor	mat	ion		
8.	For Non-Preferred Stimulants/ADHD Medications agents, list pharmaceutical agents attempted and outcome:																	
9.	Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this member.																	
	escriber Signat	• •	•	• • • • • • •	h a · · -	:f	· • • • · · ·		at c		Da	te						
	signature, the d verifiable by I	-		is the a	bove	Inforr	nation	is accur	ate									
	ase include AL omission of doc	-			-	-			-		-							
The	e completed fo	rm may b	e FAXED) to 1-8	344-27	78-573	31 , or y	ou may	call t	he nu	mber	r belo	ow.					
	C Plus: 1-800-4 edallion 4.0: 1-8																	

www.MCCofVA.com