

**Aetna Better Health® of Virginia CCC Plus and Medallion/FAMIS 4.0 REQUEST FORM
FOR STIMULANTS/ADHD MEDICATIONS FOR
CHILDREN LESS THAN FDA INDICATED AGE AND ADULTS OVER 18
Fax back to 1-855-799-2553**

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

Please use one form per member.

**Preferred stimulants/ADHD medications for individuals 4yo to 17yo do not require Service Authorization.
If your request is for a non-preferred non-stimulant please go to question 9 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:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

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Date of Birth:

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Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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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.)

Aetna Better Health® of Virginia CCC Plus and Medallion/FAMIS 4.0 REQUEST FORM:
Stimulants/ADHD Medications for
Children Less than FDA Indicated Age and Adults Over 18

Member's Last Name:

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Member's First Name:

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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, Strattera®, clonidine ER, Kapvay®, guanfacine ER, Intuniv®, 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 determined 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 the prescriber reviewed the Virginia Prescription Monitoring Program (PMP) on the date of this request?

Yes No

VIRGINIA PRESCRIPTION MONITORING PROGRAM (PMP)

https://www.dhp.virginia.gov/dhp_programs/pmp/

4. The prescriber has ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant within 30 days of this request and a copy of the most recent UDS is attached. (The urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates).

Yes No

(Form continued on next page.)

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Member's Last Name:

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Member's First Name:

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

5. The practitioner has checked the Prescription Monitoring Program at least every three months after the initiation of treatment.

Yes No

Please provide the date of the most recent check _____

6. The practitioner has ordered and reviewed a random urine drug screen at least every six months.

Yes No

Please provide the date of the most recent check _____

7. The practitioner has 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

To request a Non-Preferred agent please answer question below giving all requested information

8. For Non-Preferred Stimulants/ADHD Medications agents list pharmaceutical agents attempted and outcome:

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

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