KAISER PERMANENTE®

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Stimulants (ADHD) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Stimulants (ADHD).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□Initial Request □ Continuation of Therapy Request
□ Standard Review (72 hours)
□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

Diagnosis per the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition:

□ ADHD – Inattentive Predominant □ ADHD – Hyperactive/Impulsive Predominant □ ADHD - Combined

6 – Clinical Criteria

Patient Age Category:
□ ≤ 4 years old □ ≥ 18 years old

Has the provider reviewed the Virginia Prescription Monitoring Program? (Every 3 months during therapy)
□ No □ Yes
Date of Last Review: _____
Date of Last Opioid Rx: _____
Date of Last Benzodiazepine Rx: _____

Has the provider ordered and reviewed a urine drug screen in the past 30 days? (Every 6 months during therapy)
□ No □ Yes
Date of Last Urine Drug Screen: _____
(please attach copy)

Has the provider evaluated the patient for stimulant and/or substance use disorder, and, if present initiated specific treatment, consulted with an appropriate healthcare provider, or referred the patient for evaluation for treatment if indicated?
□ No □ Yes

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**