Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Stimulants/Kapvay SR (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

Additional Criteria if Requesting Kapvay SR:
Has the patient had a documented trial and treatment failure with ≥ 1 preferred agent prior to this request?
□ No □ Yes; □ Atomoxetine □ Guanfacine ER

Dates and Outcome: ____

7 – Provider Sign-Off

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

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

Provider Signature:	**Date:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility