Prior Authorization Request

Nevada Medicaid – OptumRx

ADHD Treatment for Recipients Age 18 and Above

Submit fax request to: 855-455-3303

Purpose: For a prescribing physician to request prior authorization for agents used for the treatment of attention deficit hyperactivity disorder (ADHD) for a recipient age 18 and above.

Questions: If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last name, First name, Middle initial:		Date of birth:
Recipient ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	
Phone:	Fax (required):	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Applicable ICD-10 code and diagnosis **or** symptom/side effect **(REQUIRED)**:		
Name:	Strength:	☐ Generic substitution not permitted
Dosage:	Duration:	

COVERAGE CRITERIA

The following criteria must be met and documented in the recipient's medical record.

Check the applicable boxes to indicate each item as true for the recipient:

- ☐ The decision to medicate for ADD or ADHD and any comorbidity is based on problems that are persistent and sufficiently severe to cause functional impairment at school, home, work and/or with peers, **and**
- ☐ Other treatable causes have been ruled out, **and**
- ☐ Initial evaluation has been done including a complete psychiatric assessment, present and past DSM-IV symptoms of ADD or ADHD, history of development and context of symptoms and resulting past and present impairment, including academic achievement and learning disorder evaluation, **and**
- ☐ There is documentation in the recipient's medical record assessing a medical history, medical or neurological primary diagnosis, and medications that could be causing symptoms, **or**
- ☐ There is documentation in the recipient's medical record assessing a history of other psychiatric disorder and treatment, **or**
- ☐ There is documentation in the recipient's medical record assessing DSM-IV symptoms of ADD and ADHD presence or absence, possible alternate comorbid psychiatric diagnosis, **or**
- ☐ There is documentation in the recipient's medical record assessing a family history including diagnosis of ADD or ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder, mood disorder and anxiety disorder, possible family stressors, or any history of abuse or neglect.
- ☐ The recipient will be using only one long-acting agent at a time for the treatment of ADD or ADHD.

Additional clinical information (required for non-preferred agents only)

- ☐ The recipient has an allergy, history of unacceptable/toxic side effects, drug-drug interaction or contraindication to all preferred agents in the same therapeutic class. *Document:*_____
- ☐ The recipient has experienced a therapeutic failure with two preferred agents in the same therapeutic class. *Document:*_____
- ☐ The non-preferred drug is being requested for a unique indication that is supported by peer-reviewed literature or FDA-approved indication that is unique to the requested drug (document diagnosis above).

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature: _____ **Date:** _____