

## ADHD Treatment for Recipients Under Age 18

**Submit request to:** Fax: 855-455-3303

**Purpose:** For a prescribing physician to request prior authorization for agents used for the treatment of attention deficit hyper-activity disorder (ADHD) for a recipient under age 18.

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

<b>DATE OF REQUEST:</b>		
<b>RECIPIENT INFORMATION</b>		
Last Name, First Name, Middle Initial:		Date of Birth:
Recipient ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
<b>PRESCRIBING PROVIDER INFORMATION</b>		
Name:	NPI:	Fax (required):
Phone:	Person to contact regarding this request:	
<b>DIAGNOSIS AND REQUESTED DRUG</b>		
Applicable ICD-10 code and diagnosis or symptom/side effect (REQUIRED):		
Name:	Strength:	<input type="checkbox"/> Generic substitution not permitted
Dosage:	Duration:	
<b>COVERAGE CRITERIA</b>		
All of the following criteria must be met <u>and</u> documented in the recipient's medical record. <b>Check the applicable boxes to indicate each item as true for the recipient:</b>		
<input type="checkbox"/> 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, <b>and</b>		
<input type="checkbox"/> Other treatable causes have been ruled out, <b>and</b>		
<input type="checkbox"/> Initial evaluation has been done by the treating physician documenting the developmental history, physical exam, medical history or neurological primary diagnosis and exam within the past 12 months, or more recently, if the clinical condition has changed, <b>and</b>		
<input type="checkbox"/> There is documentation in the recipient's medical record containing school information, standardized teachers rating scales testing reports such as TOVA, achievement test, neuropsychological testing if indicated, speech and language evaluation, <b>and</b>		
<input type="checkbox"/> There is documentation in the recipient's medical record containing the symptoms of ADD or ADHD as given by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); presence or absence-child behavior checklist; the development and context of symptoms and their resulting impairment with family, peers, and in school; history of psychiatric, psychological pediatric, or neurological treatment for ADD or ADHD; or that the member has DSM-IV symptoms of a possible alternate or comorbid psychiatric diagnosis, <b>and</b>		
<input type="checkbox"/> There is documentation in the recipient's medical record assessing a family history of ADD and ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder and other anxiety disorders, past or present family stressors, crises, or any abuse or neglect.		
<input type="checkbox"/> The recipient will be using only one long-acting agent at a time for the treatment of ADD or ADHD.		
<b>Additional clinical information (required for non-preferred agents only):</b>		
<input type="checkbox"/> The recipient has an allergy, history of unacceptable/toxic side effects, drug-drug interaction or contraindication to <u>all</u> preferred agents in the same therapeutic class. <i>Document:</i> _____		
<input type="checkbox"/> The recipient has experienced a therapeutic failure with two preferred agents in the same therapeutic class. <i>Document:</i> _____		
<input type="checkbox"/> 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).		
<b>PROVIDER CERTIFICATION – Prescriber's signature and date required.</b>		
I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.		
<b>Prescriber's Signature:</b> _____		<b>Date:</b> _____

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*