Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Attention Deficit-Hyperactive (ADHD) & Narcolepsy
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Attention Deficit-Hyperactive (ADHD) & Narcolepsy.** Please complete all sections, incomplete forms will delay processing. 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 all sections are complete.

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

Medications:

• COTEMPLA XR-ODT TBED (6 to 17 years) • DAYTRANA PTCH (6 to 17 years) • QUILLICHEW ER CHER (≥6 years) • QUILLIVANT XR SRER (≥6 years)	• AZSTARYS CAPS (≥6 years) • JORNAY PM CP24 (≥6 years) • RELEXXII TBCR (≥6 years)

1 – Patient Information

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

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?

□ Yes – please provide your provider referral number here: _____

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/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Indicate the member's age: _____.

2. **AND** member has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) as confirmed by psychoeducational testing***,
   □ No □ Yes

3. **AND** member has had an adequate trial* (1 week) and/or intolerance** or allergy to dextroamphetamine-amphetamine (generic Adderall XR), intermediate or long-acting methylphenidate (methylphenidate SR, methylphenidate CD, or methylphenidate ER), and dexmethylphenidate (generic Focalin XR)?
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Has the member continued to meet the initial review criteria and has demonstrated positive clinical response to medication?
   □ No □ Yes

***NOTES**:*

**Adequate trial of a long-acting agent is further defined as wearing off that is not resolved by increasing the dose, AND adding a short-acting agent OR increasing frequency to twice daily OR clinically significant side effects related to the dosage form that cannot be resolved by adjusting the dose or timing*

***Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment and do not require medication discontinuation*

****Criteria only applies for 18 years of age and older*

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

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

Prescriber Signature:	**Date:**