Statement of Medical Necessity for ADULT use of a C-II Stimulant

For patients ≥ 19 years of age being treated with a C-II stimulant

Fax completed form to Magellan Medicaid Administration PDL Help Desk at 800-424-7976

To expedite the prior authorization review, provide this completed form, current chart notes, and a letter of medical necessity.

BENEFICIARY INFORMATION

LAST NAME:	FIRST NAME:
MEDICAID ID NUMBER:	DATE OF BIRTH:

PRESCRIBER INFORMATION

LAST NAME:	FIRST NAME:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:

REQUESTED MEDICATION:

STRENGTH:

DIRECTIONS:

As an alternative to using a C-II stimulant

Atomoxetine, clonidine IR, and guanfacine IR do not require prior approval for treating adult ADD/ADHD.

1. Does your patient have a diagnosis of ADHD? ☐ **YES** (continue to question 2) ☐ **NO** (continue to question 9)
2. Provide the goals of drug therapy:
____
____
3. How and when was ADD/ADHD diagnosed in this adult patient:
____
4. List current behavioral therapies for ADHD:
____
____
5. List the patient's specific DSM-V ADD/ADHD symptoms for the **initial** request **(for PA renewals, skip to question 6)**:
____
____
____
____
____
6. As an **adult**, does your patient attend school? ☐ **YES** ☐ **NO**

If **YES**, does your patient have **clinically significant impairment** due to ADD/ADHD symptoms present in the academic/school setting? ☐ **YES** ☐ **NO**

If **YES**, Name of school____

High school grade/college level____

If attending college or vocational school, number of hours per semester: ___________

7. As an **adult**, is your patient employed? ☐ **YES** ☐ **NO**

If **YES**, does your patient have **clinically significant impairment** due to ADD/ADHD symptoms present in the occupational/work setting? ☐ **YES** ☐ **NO**

If **NO**, describe reason this patient is not employed:

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8. As an **adult** if not employed or in school, is your patient seeking employment? ☐ **YES** ☐ **NO**

If **YES**, does your patient have **clinically significant impairment** due to ADD/ADHD symptoms that impacts the ability to seek employment? ☐ **YES** ☐ **NO**

If **NO**, describe the medical necessity of continued treatment when the patient does not have symptoms impacting academic or occupational settings (patients will be **limited to 3 months** of treatment to aid in seeking employment):

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For ADD/ADHD patients not attending school or employed, provide the medical necessity for a CII stimulant.

9. Diagnosis other than ADD/ADHD **(mark one)**:
   - ☐ Narcolepsy (provide sleep study results confirming diagnosis on initial request)
   - ☐ Traumatic Brain Injury (TBI)
   - ☐ Fatigue due to underlying illness (i.e., cancer or multiple sclerosis)
   - ☐ Binge Eating Disorder (BED)—Vyvanse only
   - ☐ Other: ______________________________

10. If your patient has any of the following conditions, please address as follows:

	Condition		
a.	Hypertension	☐**TREATED**	☐ **CONTROLLED**
b.	Cardiovascular disease, chest pain, arrhythmias or CHF	☐**TREATED**	☐ **CONTROLLED**
c.	Diabetes	☐**TREATED**	☐ **CONTROLLED**
d.	Bipolar Disease	☐**TREATED**	☐ **CONTROLLED**
e.	Schizophrenia	☐**TREATED**	☐ **CONTROLLED**
f.	Drug abuse	☐**TREATED**	☐ **CONTROLLED**
g.	Alcohol abuse	☐**TREATED**	☐ **CONTROLLED**
h.	Anorexia/Bulimia	☐**TREATED**	☐ **CONTROLLED**

Provide additional information regarding any conditions marked in question #10.

If your patient continues to have symptoms of bipolar disease or schizophrenia OR is nonadherent to appropriate medication therapy, provide the medical necessity for ADHD medication use.

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11. Does your patient have a history of drug abuse or alcohol abuse? ☐ **YES** ☐ **NO**

12. If yes to question 11, does your patient currently receive counseling? ☐ **YES** ☐ **NO**

If **YES**, fax written documentation of substance abuse counseling. Documentation should include date, time, type of therapy or counseling and location. If the counseling is done offsite, provide the phone number and name of person providing the counseling. If counseling is done onsite, provide the chart notes correlating to the visits.

If **NO**, has the patient had counseling in the past? ☐ **YES** (describe when and where) ☐ **NO** (explain why not)

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______________________________ ______________________________

Prescriber Signature (Original Signature Required) ***Date***

This signature certifies that the information provided in the Statement of Medical Necessity is accurate and substantiated by the patient's medical record.