Stimulants

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-396-4139 FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ☐ Brand ☐ Generic	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, did member show improvement while on therapy?**	☐ **Yes** ☐ **No**

Please indicate the diagnosis on the left and include the requested information.

FOR MEMBERS UNDER 4 YEARS OF AGE:

☐ **Attention Deficit Hyperactivity Disorder (ADHD)**	**Please submit documentation of a comprehensive evaluation by or in consultation with a pediatric neurologist, a child and adolescent psychiatrist, or a child development pediatrician.**
☐ **Brain injury**	
☐ **Autism**	
☐ **Other Diagnosis**	

FOR MEMBERS 18 YEARS OF AGE AND OLDER:

☐ Attention Deficit **Hyperactivity Disorder (ADHD)**	**Has the member been on the requested medication since before turning 18 years of age?** **If no, please submit documentation of ADHD screening.**	☐ Yes ☐ No
☐ Narcolepsy	**Please submit documentation of the sleep study confirming the diagnosis.**	
☐ Autism		
☐ Other **Diagnosis**	**Please submit documentation of a comprehensive evaluation by the prescriber and include clinical rationale for use of the requested medication.**	

HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Trial/ Previous Therapies	Dates of Therapy Start Date	End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

Please provide any additional information which should be considered in the space below: