oklahoma complete health

Prior Authorization Request Form

Stimulants for Children under the age of 5

CoverMyMeds is the preferred way to submit this form. **https://www.covermymeds.com/main/prior-authorization-forms/**
OR FAX completed form to 1-844-235-5092
OR MAIL requests to: Centene Pharmacy Services Coverage Determinations| P.O. Box 31397 |Tampa, FL 33631-3397
OR CALL 1-833-331-1515 (SoonerSelect) or 1-833-655-0896 (SoonerSelect Children's Specialty Program)

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber name:	Member name:
Form Submitter name:	Member ID#
Provider NPI:	Group number (optional):
Fax:	Date of Birth:
Phone:	Relevant allergies (if any):

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage form:	Dosage Interval (sig):	Qty per Day:

Diagnosis(es) relevant to this request: ☐ ADHD, inattentive type ☐ ADHD, hyperactive type ☐ ADHD, combined type
☐Other (specify):

Expected length of therapy:

Medication History for this Diagnosis

If this is a new request, please go to item E. If the member is currently treated on this medication, please go to item A.

A. How long has this member been treated on this medication?

B. Is this request for continuation of a previous approval? ☐ yes [go to item D] ☐ no / unknown [go to item C]

C. Has strength, dosage, or quantity required per day increased or decreased? ☐ yes [go to item D] ☐ no [go to item D]

D. ***Please check each box and sign at the bottom.***

☐ **Documentation (including office chart notes) of the below items is attached:**

1. ADHD Follow Up visit/s by a physician which include:
   1. Current ADHD symptoms
   2. Side effects and benefits of ADHD medication.
   3. Reason for formulation or dose change.
   4. Vitals signs including weight, height, BMI, pulse, and blood pressure.
   5. ADHD follow up screening tool such as the follow up Vanderbilt from 2 sources.
   6. Documentation of psychosocial support and/or continued therapy.
2. Patient was on the initial dose for a minimum of 4 weeks.

☐ **The requested Methylphenidate dose does not exceed 1mg/kg/day OR Dextroamphetamine or mixed amphetamine salts. dose does not exceed 0.5 mg/kg/day.**

☐ (***Check this box if applicable***) **If the request is for a change from a short acting formulation to a long acting/extended release. formulation the appropriate short acting dose has been achieved before changing.** (A minimum trial of up to 20mg of methylphenidate daily or 10mg of dextroamphetamine or mixed amphetamine salts daily)

E. ***Please check each box and sign at the bottom.***

☐ **Documentation (including office chart notes) of the below items is attached:**

1. A child psychiatry evaluation by a child psychiatrist **OR** consultation with a child psychiatrist with a recommendation of a stimulant trial.
   a. Providers can register for the free, statewide Pediatric Mental Health Access Program, the Oklahoma Child and Adolescent Psychiatry and Mental Health Access Program for access to child psychiatry consultations 9-5AM, M-F. www.okcapmap.com.
2. Risk, benefits, side effects and alternatives presented to the guardian.
3. Evaluation of psychosocial issues.
4. Rule out of medical issues such as hearing loss
5. Consideration of co-morbid developmental language disorder, Specific Learning Disorder, or Autism Spectrum Disorder.
6. Vitals signs including weight, height, BMI, pulse, and blood pressure.
7. Documented ADHD screening tool results (e.g. Vanderbilt ADHD Rating Scale) from 2 sources (e.g. caregiver and childcare worker).
8. Documentation of Parent Management Training or other Behavioral intervention for a minimum of 12 weeks.
9. Documented continued impairment after non-medication intervention.

☐ **The requested dose does NOT exceed the dosing guidelines below.**

   a. Methylphenidate IR 5mg po q AM
   b. Amphetamine Salts/Dextroamphetamine IR 2.5mg po q AM

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The Oklahoma Complete Health Formulary is available on their website at **https://www.oklahomacompletehealth.com/providers/pharmacy.html.**

IV. ADDITIONAL INFORMATION (OPTIONAL)

Appropriate clinical information to support the request based on medical necessity must be attached.	Provider Signature:	Date:

Pharmacy Services will respond via fax or phone within 24 hours of receipt. Requests for prior authorization (PA) must include member name and ID#, and drug name. **Incomplete forms will delay processing.** For additional questions or to expedite this request, please call numbers listed above.