CareSource PASSE

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 for ADD/ADHD

Fax completed form to CareSource PASSE Pharmacy Help Desk at 1-866-930-0019.

For questions, contact Provider Services at 1-833-230-2100.

BENEFICIARY INFORMATION

BENEFICIARY LAST NAME:

BENEFICIERY FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: ___ - ___ - ___

BENEFICIARY STREET ADDRESS:

CITY

STREET ADDRESS LINE 2:

STATE:

ZIP CODE:

Prescriber Information

PRESCRIBER LAST NAME:

PRESCRIBER FIRST NAME:

PRESCRIBER STREET ADDRESS:

CITY

STREET ADDRESS LINE 2:

STATE:

ZIP CODE:

NPI NUMBER:

DEA NUMBER:

PHONE NUMBER: ___ - ___ - ___

FAX NUMBER: ___ - ___ - ___

REQUESTED MEDICATION:______________________________

STRENGTH AND DOSAGE FORM:______________________________

DIRECTIONS:______________________________

PLEASE NOTE:

As an alternative to using a C-II stimulant, Strattera, Clonidine IR and Guanfacine IR do not require prior approval for treating adult ADD.

1. Please state the diagnosis requiring the requested C-II stimulant:

____

____

2. Please provide the goals of drug therapy:

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____

3. What methods have been used to evaluate ADD/ADHD for this adult patient?

____

____

Date of most recent evaluation: ______________________________

4. Please list current behavioral therapies for ADHD:

____

____

5. 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: ______________________________

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

If **YES**, name of employer: ______________________________

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

   If **YES**, name of employer: ____________________

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

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

   ____

   ____

   ____

7. 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 congestive heart failure	☐ 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

   Please provide additional information regarding any conditions marked in question #7.

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8. If patient has a history of drug abuse or alcohol abuse, is the patient currently receiving counseling? ☐ Yes ☐ No

   IF YES on question 8 above, 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, please provide the phone number and name of person providing the counseling. If counseling is done onsite, please provide the chart notes correlating to the visits.

   If NO on question 8 above, has the patient had counseling in the past? If YES to this, describe when and where

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9. Please list the patient's specific DSM-IV or DSM-V ADD/ADHD symptoms:

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   ____

   ____

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****To expedite the prior authorization review, please provide this completed form, current chart notes, and a letter of medical necessity if the above patient is not in school or working.****

____________________ ____________________

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

Prescriber's original signature required; copied, stamped, or e-signature are not allowed.

This signature certifies that the information provided in the Statement of Medical Necessity is accurate and substantiated by the patient's medical records. The prescriber also agrees that Medicaid may review this patient's medical records to ascertain the medical necessity for accuracy of data submitted for this request for a C-II stimulant for treatment of adult ADD/ADHD.

Fax This Form to: CareSource PASSE Help Desk at 1-866-930-0019.

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