CareSource PASSE

Arkansas Medicaid
Statement of Medical Necessity for
Adult Patients ≥ 19 Years of Age Being Treated with a C-II Stimulant

Fax this form to **1-866-930-0019** for Pharmacy benefit.

Incomplete or illegible forms may delay processing of the prior authorization (PA).

Non-Urgent ☐ Urgent ☐

Please read before starting this request:
As alternatives to using a C-II stimulant:

Atomoxetine, clonidine IR and guanfacine IR do not require prior approval for treating adult ADD/ADHD. Qelbree® is non-preferred and requires documentation of medical necessity over atomoxetine and preferred C-II stimulants.

BENEFICIARY INFORMATION (one request per form) **Request Date:** _____

Beneficiary Last Name: _____ Beneficiary First Name: _____

AR Medicaid Beneficiary ID: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____ Prescriber First Name: _____

Prescriber National Provider Identifier (NPI): _____

Drug Enforcement Administration (DEA) Number: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

Dosage Form: _____

Directions: _____

DIAGNOSIS

Diagnosis: _____ Diagnosis Code: _____

Beneficiary Name: _____

CLINICAL INFORMATION

1. Does the patient have a diagnosis of ADHD? ☐ Yes (skip to question 2) ☐ No (skip 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. Does the adult patient attend school? ☐ Yes ☐ No

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

   If **Yes**, provide name of school: _____
   High School Grade/College Level: _____

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

7. Is the adult patient employed? ☐ Yes ☐ No

   If **Yes**, does the patient have clinically significant impairment due to ADD/ADHD symptoms present in the occupational/work setting?

   If **Yes**, provide name of employer: _____

   If **No**, describe reason this patient is not employed: _____

   For ADD/ADHD patients *not* attending school or employed, provide the medical necessity for a C-II stimulant: _____

   _____

8. If the adult patient is neither employed nor in school, are they seeking employment? ☐ Yes ☐ No

   If **Yes**, does the patient have clinically significant impairment due to ADD/ADHD symptoms that impact their 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 three months of treatment to aid in seeking employment): _____

   _____

Beneficiary Name: _____

9. Diagnosis other than ADD/ADHD (select one):
   - ☐ Narcolepsy (provide sleep study results confirming diagnosis on initial request)
   - ☐ Traumatic brain injury (TBI)
   - ☐ Fatigue due to underlying illness (e.g., cancer or multiple sclerosis)
   - ☐ Binge Eating Disorder (BED) – Vyvanse® only
   - ☐ Other: _____

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

Hypertension: ☐ Treated ☐ Controlled	Schizophrenia: ☐ Treated ☐ Controlled
Heart disease (arrhythmias, failure, chest pain, etc.): ☐ Treated ☐ Controlled	Drug abuse: ☐ Treated ☐ Controlled
Diabetes: ☐ Treated ☐ Controlled	Alcohol abuse: ☐ Treated ☐ Controlled
Bipolar disease: ☐ Treated ☐ Controlled	Anorexia/bulimia: ☐ Treated ☐ Controlled

Provide additional information regarding any conditions selected above:

_____

If the patient continues to have symptoms of bipolar disease or schizophrenia **or** is non-adherent to medication therapy, provide the medical necessity for ADHD medication use:

_____

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, including, dates, times and type of therapy or counseling and location. Offsite, provide the phone number and name of person providing the counseling. Onsite, provide the chart notes correlating to the visits.

    If **No**, has the patient had counseling in the past?
    ☐ Yes ☐ No

    If **Yes**, describe when and where: _____

    If **No**, explain why not: _____

    _____

    ☐ Attachments

Prescriber Signature: _____ **Date:** _____

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