VA Premier Health Plan, Inc. ENVISIONRX OPTIONS

ADULT ADHD Therapies - Prior Authorization Request
Submit request via fax to EnvsionRxOptions: 877-503-7231

The purpose of this record is for coverage determination. The patient's medical record must substantiate the information provided on this form. Virginia Premier reserves the right to request chart **records to** confirm the information **provided below.**

GENERAL INFORMATION			
Patient Name:	Patient DOB:	VPHP ID #:	
Prescriber:	NPI #:		
Practice Address:	City:	State:	Zip:

Ongoing hyperactive-impulsive or inattentive symptoms due to ADHD must be present in adulthood ***to the extent that they cause clinically significant impairment in social, academic, or occupational performance*** and **NOT** because of other comorbid diagnoses or other potential medical confounders such as interacting medication or medication adverse effects (such as side effects from benzodiazepines, thyroid disease, sleep apnea or other mental disorders such as inadequately treated depression, bipolar disorder)

PLEASE ANSWER THE FOLLOWING QUESTIONS & SIGN BELOW	
1. Have you checked the Virginia Prescription Monitoring Program profile for this patient? **This is required for approval.**	☐ Yes ☐ No
2. Was the diagnosis before age 16?	☐ Yes ☐ No
If yes, was it treated with a stimulant and do you have the records?	☐ Yes ☐ No

If yes, which symptoms are still significant enough to warrant initiation of treatment again in adulthood? If treatment had been discontinued what was the reason for discontinuation and have the issues been addressed before it is restarted? Be patient and detail specific.

3. For new diagnoses after age of 16 and continuation, please list symptoms, goal of treatment, and how improvements will be measured to meet outcome goal? Be patient and detail specific

Please list patient specific behavior modification therapy, non-drug treatment, education, and other therapies used for treatment of ADHD BEFORE initialization of a CII stimulant:

4. Has patient signed an informed consent contract? **This is required for approval**.	☐ Yes ☐ No
5. Does the patient have a history of Substance Abuse/Dependence, Seizures or Anorexia/Bulimia? If yes, list treatment:_____	☐ Yes ☐ No

6. Are there other mental health diagnoses before ADHD diagnosis? Mark all that apply:

CONDITION	LIST CURRENT MEDICATIONS
☐Bipolar Disorder	
☐Generalized Anxiety Disorder	
☐Personality Disorder	
☐Schizophrenia	
☐Thyroid	
☐Other:	

7. Medication Requested: _____ **Note: frequency & duration must not exceed FDA limits**	Strength:	Quantity:	Directions:

If medication is for nonpreferred medication please list reasons why therapy was discontinued and why a nonpreferred agent should be approved? **Failure of two preferred agents and documentation of a medical reason why the preferred agent cannot be used is required before authorization for a non-preferred agent will be approved.**

Physician Signature (required):_____ Date: _____

This signature certifies that the information provided here is accurate and substantiated by the patient's medical records.

Virginia Premier INFORMED CONSENT FORM FOR CNS STIMULANTS

The purpose of this agreement is to give you information about the medications you will be taking for ADHD and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances.

I have agreed to use a CNS amphetamine derived stimulant for the treatment of ADHD. I understand that these drugs can be safe and useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. By signing this document I acknowledge that:

1. I understand these medications are controlled substances. They are highly regulated by state and federal law because of their potential for abuse, misuse, addiction, and diversion.
    a. I understand that it is a **felony** to acquire these medications inappropriately without a prescription or to give or sell them to anyone.
2. I will not request other controlled medication prescriptions from any other prescriber. Any controlled prescriptions will be written by only one regular prescriber.
    a. I acknowledge that mixing stimulant medications with other prescription medications, over-the-counter medications, alcohol, or other drugs can be dangerous.
        i. I will inform my physician of all medications I am taking, including herbal remedies. Medications like Valium, Ativan, Xanax, or Klonopin; nasal decongestants such as pseudoephrindrine; herbal products, alcohol, and cough syrups can interact with my medication.
    b. I will not use any illicit substances, such as cocaine, marijuana, etc. while taking this medication. This may result in a change to my treatment plan, including safe discontinuation of my medications or complete termination of the doctor/patient relationship.
    c. If I develop anxiety or panic attacks while on this medication, I agree this medication will be decreased or changed. A medication such as a benzodiazepine will not be prescribed to treat a side effect since dangerous interactions and overdoses have occurred that way.
3. I agree to take the medication only as prescribed.
    a. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to depression and withdrawal.
    b. I understand that increasing my dose without the close supervision of my physician could lead to drug hypertensive crisis, overdose, or even death.
    c. If I do not use all of the medication prescribed on a monthly basis, I will let my physician know at my next visit how many tablets I have left and what days I don't need medication.
    d. I take full responsibility to secure both the prescription and the medication safely so that they are not misplaced, lost, or misused by others.
4. I am aware of the side effects of taking a controlled schedule II substance for ADHD. This medication can produce side effects including, but not limited to, insomnia, headache, cardiovascular issues, and emotional issues psychosis, and tolerance. Addiction is also a risk if this medication is used other than its prescribed use, or in dosages above those prescribed.

By signing this document, I acknowledge I have read the above information, that I will abide by all parts of it and that failure to do so will result in termination of my stimulant medication.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____