Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Strattera and Cerebral Stimulant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Strattera (atomoxetine). In addition, PA is required for greater than 60 units per month for long-acting cerebral stimulants, greater than 90 units per month for short-/intermediate-acting cerebral stimulants, and concurrent therapy for short-/intermediate-and long acting cerebral stimulants greater than 90 units per month (all agents combined). PA is also required for any brand-name multiple-source product that has an FDA "A"-rated generic equivalent as identified by the Approved Drug Products with Therapeutic Equivalence Evaluations (also called the "Orange Book"). Additional information about Strattera and Cerebral Stimulant use can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Stratera Request ☐ Strattera (atomoxetine)	Dose, frequency, and duration	Drug NDC (if known)

Cerebral Stimulant Request (Check one or all that apply.)

Long Acting
- ☐ Adderall XR (amphetamine salts)
- ☐ Concerta (methylphenidate)
- ☐ Focalin XR (dexmethylphenidate)
- ☐ Metadate CD (methylphenidate)
- ☐ Ritalin LA (methylphenidate)

Intermediate Acting/Short Acting
- ☐ Adderall# (amphetamine salts)
- ☐ Focalin (dexmethylphenidate)
- ☐ Dexedrine# (dextroamphetamine)
- ☐ Dextrostat# (dextroamphetamine)
- ☐ Liquadd (dextroamphetamine)
- ☐ Metadate ER# (methylphenidate)
- ☐ Methylin (methylphenidate)
- ☐ Ritalin# (methylphenidate)
- ☐ Ritalin SR# (methylphenidate)

Indication (Check one or all that apply.)
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Narcolepsy
- ☐ Other (Explain)

Dose, frequency, and duration

Drug NDC (if known)

Quantity requested per month

Has dose consolidation been attempted? ☐ Yes ☐ No
Please explain why not.

Is member under the care of a psychiatrist or behavioral specialist? ☐ Yes ☐ No

Name of psychiatrist or behavioral specialist _____

Telephone no.: _____ Date of last visit: _____

Please list all medications currently prescribed for this member for this condition.

Please describe your new treatment plan for managing this member's condition, including discontinuation of any medications as a result of the addition of medication requested.

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Medication information (cont.)

Please complete the following sections for Strattera requests.

Has member tried other medications in the methylphenidate class (i.e., Concerta, Focalin, Metadate, Methylin, or Ritalin) to treat this condition? ☐ Yes. Complete box A. ☐ No. Explain why not. _____

A. Drug name	Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____

Has member tried other medications in the amphetamine/dextroamphetamine class (i.e., Adderall or Dexedrine) to treat this condition?

☐ Yes. Complete box B. ☐ No. Explain why not. _____

B. Drug name	Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____

Has member tried other non-stimulant medications to treat this condition?

☐ Yes. Complete box C. ☐ No. Explain why not. _____

C. Drug name	Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*	
Address		City	State	Zip *Optional*

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date