Statement of Medical Necessity for ADULT use of a C-II stimulant

For patients ≥ 18 years of age who are being treated with a C-II stimulant for ADD/ADHD, please fax the completed form to Empower Healthcare Solutions at 866-546-0484. If additional Information is needed, please call 844-865-7829

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per beneficiary please.

Beneficiary Information

LAST NAME: ____________ **FIRST NAME:** ____________

MEDICAID ID NUMBER: ____________ **DATE OF BIRTH:** __ – __ – ____

Prescriber Information

LAST NAME: ____________ **FIRST NAME:** ____________

NPI NUMBER: ____________ **DEA NUMBER:** ____________

PHONE NUMBER: ___ – ___ – ____ **FAX NUMBER:** ___ – ___ – ____

REQUESTED GENERAL/NON-PREFERRED DRUG

MEDICATION: ____________ **STRENGTH:** ____________ **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 reason for prescribing the requested C-II ____________

   Please provide reason for or goal of drug therapy ____________

2. Has this patient been evaluated as an adult for ADD/ADHD? ☐ Yes ☐ No
3. What evaluation tools have been used to evaluate ADD/ADHD for this adult patient?

   Date of 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 academic/school setting? ☐ Yes ☐ No

   If YES, **Name of school** ____________ high school grade/college/ vocational level ____________

   If attending college or vocational school, number of hours per semester ____________

6. **As an adult, is your patient employed?** ☐ Yes ☐ No

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

   If YES, name of **place of employment** ____________

   If NO, describe reason for non-employment? ____________

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

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.

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

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

Prescriber Signature (Required)

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.

Date

Fax This Form to: Empower Healthcare Solutions at 866-546-0484.
If additional Information is needed, please call 844-865-7829.