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# Arkansas Medicaid

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

Fax completed form to Empower Healthcare Solutions: 1-866-546-0484

To expedite the prior authorization review, provide this completed form, current chart notes, and a letter of medical necessity.

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per beneficiary. Information contained in this form is protected health information under HIPAA.

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

Medicaid ID: _____ Date of Birth: _____

Beneficiary Last Name: _____

Beneficiary First Name: _____

### PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ DEA Number: _____

Prescriber Phone: _____ Prescriber Fax: _____

### DRUG INFORMATION

Drug Name: _____

Drug Strength: _____ Dosage Form: _____

Directions: _____

### 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:

   _____

Beneficiary Name: _____

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?

   ☐ Yes ☐ No

   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 3 months of treatment to aid in seeking employment):

   _____

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: _____

Beneficiary Name: _____

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

Hypertension:
☐ Treated ☐ Controlled

Heart disease (arrhythmias, failure, chest pain, etc.):
☐ Treated ☐ Controlled

Diabetes:
☐ Treated ☐ Controlled

Bipolar disease:
☐ Treated ☐ Controlled

Schizophrenia:
☐ Treated ☐ Controlled

Drug abuse:
☐ Treated ☐ Controlled

Alcohol abuse:
☐ 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 appropriate 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. Documentation should include date, time, type of therapy or counseling and location. If the counseling is done offsite, provide the phone number and name of person providing the counseling. If counseling is done 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.

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