**FAX** completed form to
**Change Healthcare**
**1-866-964-3472**

Wyoming Medicaid – Pharmacy Services Program
PRIOR AUTHORIZATION REQUEST FORM

# Adult ADHD Treatment

**PHONE:**
**(For questions or inquiries ONLY)**
**1-877-207-1126**

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Client's Full Name: _____ DOB: _____

Prescriber NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Pharmacy Name: _____ Phone: _____

| **Drug Name** (List one drug per form) | **Strength** | **Dosage Instructions** | **Days Supply** | **Quantity** | **Refills** |
|---|---|---|---|---|---|

1. **Client's Medical Diagnosis: _____**
2. **Does the client have an intellectual or developmental disability?** ☐ **Yes** ☐ **No**

   If yes, please provide the ICD-10 code associated with that disability: _____
3. **Does the client have five or more symptoms of inattention that have been present for at least 6 months and are inappropriate for developmental level?** ☐ **Yes** ☐ **No**
4. **Does the client have five or more symptoms of hyperactivity and impulsivity that have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level?** ☐ **Yes** ☐ **No**
5. **Is there clear evidence that this client's symptoms interfere or reduce the quality of social, school, or work functioning?** ☐ **Yes** ☐ **No**
6. **Can the client's symptoms be associated with another mental disorder?** ☐ **Yes** ☐ **No**

   If yes, please provide what mental disorder: _____
7. **Are the client's symptoms present in two or more settings?** ☐ **Yes** ☐**No**

   If yes, please check all that apply:

   ☐ Home
   ☐ Work
   ☐ School

   If no, please provide details of client's diagnosis history below including date of initial diagnosis and if the symptoms were present in two or more of the settings listed above at the time of diagnosis:

_____

_____

_____

_____

**8. If requesting a *non-preferred* agent, please list the "preferred" alternatives that have been tried and why they were discontinued:**

| | Medication | Dates of use | Reason for Discontinuing |
|---|---|---|---|
| **A.** | _____ | _____ | _____ |
| **B.** | _____ | _____ | _____ |
| **C.** | _____ | _____ | _____ |

**Prescriber Signature: _____ Date(s) of Submission: _____**

**** Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.***