Prior Authorization Request
Nevada Medicaid – Molina Healthcare

ADHD Treatment for Recipients Under Age 18

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

DATE OF REQUEST:		
MEMBER INFORMATION		
Last Name, First Name, Middle Initial:		Date of Birth:
Molina ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	Fax (required):
Phone:	Person to contact regarding this request:	
DIAGNOSIS AND REQUESTED DRUG		
Applicable ICD-10 code and diagnosis **or** symptom/side effect **(REQUIRED)**:		
Name:	Strength:	☐ Generic substitution not permitted
Dosage:	Duration:	

COVERAGE CRITERIA

All of the following criteria must be met and documented in the recipient's medical record.
Check the applicable boxes to indicate each item as true for the recipient:

- ☐ The decision to medicate for ADD or ADHD and any comorbidity is based on problems that are persistent and sufficiently severe to cause functional impairment at school, home, work and/or with peers, **and**
- ☐ Other treatable causes have been ruled out, **and**
- ☐ Initial evaluation has been done by the treating physician documenting the developmental history, physical exam, medical history or neurological primary diagnosis and exam within the past 12 months, or more recently, if the clinical condition has changed, **and**
- ☐ There is documentation in the recipient's medical record containing school information, standardized teachers rating scales testing reports such as TOVA, achievement test, neuropsychological testing if indicated, speech and language evaluation, **and**
- ☐ There is documentation in the recipient's medical record containing the symptoms of ADD or ADHD as given by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); presence or absence-child behavior checklist; the development and context of symptoms and their resulting impairment with family, peers, and in school; history of psychiatric, psychological pediatric, or neurological treatment for ADD or ADHD; or that the member has DSM-IV symptoms of a possible alternate or comorbid psychiatric diagnosis, **and**
- ☐ There is documentation in the recipient's medical record assessing a family history of ADD and ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder and other anxiety disorders, past or present family stressors, crises, or any abuse or neglect.
- ☐ The recipient will be using only one long-acting agent at a time for the treatment of ADD or ADHD.

Additional clinical information (required for non-preferred agents only):

- ☐ The recipient has an allergy, history of unacceptable/toxic side effects, drug-drug interaction or contraindication to all preferred agents in the same therapeutic class. *Document:*_____
- ☐ The recipient has experienced a therapeutic failure with two preferred agents in the same therapeutic class. *Document:*_____
- ☐ The non-preferred drug is being requested for a unique indication that is supported by peer-reviewed literature or FDA-approved indication that is unique to the requested drug (document diagnosis above).

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature:_____ **Date:** _____