MOLINA HEALTHCARE
Service Authorization (SA) Form
For Stimulants/ADHD Medications for Children under 4 or Adults 18 Years of Age and Older

If the following information is not complete, correct, and legible, the SA process could be delayed. Please use one form per member.

Preferred stimulants/ADHD medications for individuals 4 to 17 years old do not require Service Authorization.

If your request is for a non-preferred non-stimulant, please go to question 8 and submit form. Stimulants prescribed for children under the age of 4 must be prescribed by a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists

MEMBER INFORMATION

Last name: ☐☐☐☐☐☐☐☐☐☐☐☐

First name: ☐☐☐☐☐☐☐☐☐☐☐☐

Medicaid ID number: ☐☐☐☐☐☐☐☐☐☐☐☐

Date of birth: ☐☐☐☐ ☐☐☐☐

Gender: ☐ **Male** ☐ **Female**

Weight in kilograms: ______________________

PRESCRIBER INFORMATION

Last name: NPI ☐☐☐☐☐☐☐☐☐☐☐☐

First name: ☐☐☐☐☐☐☐☐☐☐☐☐

number: ☐☐☐☐☐☐☐☐☐☐

Phone number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Fax number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

If the member is under the age of 4 and you are prescribing a stimulant:

Are you a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician or in consultation with one of these specialists?

☐ Yes ☐ No

(Form continued on next page.)

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VA-ALL-PF-13194-23

Member's last name: | | | | | | | | | | | |

Member's first name: | | | | | | | | | | | |

DRUG INFORMATION

Drug name/Form: ____

Strength: ____

Dosing frequency: ____

Length of therapy: ____

Quantity per day: ____

DIAGNOSIS AND MEDICAL INFORMATION

Stimulants/ADHD Medications for Adults Over 18: To receive an approval for this drug, complete the following questions. This does not apply to non-stimulant ADHD medications (such as atom- oxetine, Strattera®, clonidine ER, Kapvay®, guanfacine ER, Qelbree®, Qelbree®, Intuniv®)

Does the member meet the following criteria?

1. Indicate the diagnoses being treated (include all ICD codes, if applicable):

   ____

2. Did the primary care clinician use the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* and determine that criteria have been met (including documentation of impairment in more than 1 major setting) to make the diagnosis of ADHD?

. ☐ Yes ☐ No

(Form continued on next page.)

Member's last name: | | | | | | | | | | | |

Member's first name: | | | | | | | | | | | |

Does the member meet the following criteria for the maintenance request?

3. Has the practitioner regularly evaluated the member for stimulant and/or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate health care provider, or referred the member for evaluation for treatment if indicated?

☐ Yes ☐ No

To request a Non-Preferred agent, please answer the question below, giving all requested information

4. For Non-Preferred Stimulants/ADHD Medications agents, list pharmaceutical agents attempted and outcome:

____

5. Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this member.

____

____ ______________________

Prescriber signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **faxed to (844) 278-5731**, or you may call **(800) 424-4518. (TTY: 711)**.