STIMULANTS
PRIOR AUTHORIZATION FORM

NOTES:

- **Prescribers: To avoid filling out and submitting this form** for preferred drugs, write the diagnosis code on the face of the prescription to allow an automated PA to process at the pharmacy.
- **Pharmacists: To enable automated PA**, please **enter the diagnosis code** at the point of sale.
- The list of preferred and non-preferred drugs is available at https://kyportal.medimpact.com/
- When complete, please fax to **Kentucky MCO PA Fax: 1-858-357-2612**
- Kentucky MCO PA Phone: 1-844-336-2676

Drug Name:	Permission to substitute the preferred product (eg atomoxetine for Strattera) ☐ Yes ☐ No
Quantity:	Days Supply:
Directions for Use:	
Member Name:	Member ID:
Member Date of Birth:	Member Age:
Member Address:	
Sex: ☐ Male ☐ Female	Member's ICD Code or Diagnosis:

Requester: ☐ Prescriber's office ☐ Pharmacy	Your name:
Prescriber / Pharmacy Name:	
Prescriber / Pharmacy Address:	
If a Prescriber, Specialty:	Prescriber / Pharmacy NPI:
Prescriber Phone:	Prescriber Fax:
Pharmacy Phone:	Pharmacy Fax:
On behalf of the Prescriber, I certify that the information in this form is true, made to allow Kentucky Medicaid to offer prescription coverage to the member for the medication requested. I understand the health plan will retain this document and any attached materials for the purpose of possible future audit(s).	
Your Signature:	Date:

GENERAL QUESTIONS FOR ALL REQUESTS	
Are you requesting a brand or non-preferred product?	☐ Yes ☐ No
If you ARE requesting a non-preferred product, has the patient had a trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of ONE preferred product?	☐ Yes ☐ No
If you ARE requesting a brand product, has the patient tried and failed (e.g., allergy or intolerance to an inactive ingredient) TWO manufacturers of the corresponding generic?	☐ Yes ☐ No

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ADDITIONAL QUESTIONS FOR VYVANSE FOR THE TREATMENT OF BINGE EATING DISORDER ONLY	
If for moderate to severe binge eating disorder, has a comprehensive evaluation, including a physical exam and any necessary labs, been performed and appropriately documented?	☐ Yes ☐ No
If for moderate to severe binge eating disorder, has the patient been counseled on the benefits of cognitive behavioral therapy (CBT) and referred if appropriate.?	☐ Yes ☐ No
Is this a request for the RENEWAL of a previous Vyvanse prior authorization?	☐ Yes ☐ No
If this request IS for RENEWAL, has the disease response been documented and/or evaluated using a validated tool?	☐ Yes ☐ No

ADDITIONAL QUESTIONS FOR NON-SOLID DOSAGE FORMS ONLY	
Is the patient unable to swallow or tolerate solid dosage forms?	☐ Yes ☐ No
If the request is for METHYLPHANIDATE CHEWABLE, is the patient unable to tolerate the solution?	☐ Yes ☐ No

ADDITIONAL QUESTIONS FOR THERAPEUTIC DUPLICATION ONLY	
Is the patient switching from one agent to another?	☐ Yes ☐ No
Does the prescribed dose require two different strengths of the same medication because the dosage cannot be achieved otherwise?	☐ Yes ☐ No
Is the request for more than one long-acting and/or more than one short-acting agent (the same agent or different agents)?	☐ Yes ☐ No
Is the request for twice daily dosing, using different doses of the same agent?	☐ Yes ☐ No