Magellan COMPLETE CARE®

MAGELLAN COMPLETE CARE OF VIRGINIA – CCC PLUS

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 9 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:

First Name:

NPI 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

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

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 atomoxetine, Strattera®, clonidine ER, Kapvay®, guanfacine ER, 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

3. Has the prescriber reviewed the Virginia Prescription Monitoring Program (PMP) on the date of this request?
   See: **Virginia Prescription Monitoring Program (PMP)**
   https://www.dhp.virginia.gov/PractitionerResources/PrescriptionMonitoringProgram/

   ☐ Yes ☐ No

4. The prescriber has ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant within 30 days of this request and a copy of the most recent UDS is attached. (The urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates).

   ☐ Yes ☐ No

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

5. Has the practitioner checked the Prescription Monitoring Program at least every three months after the initiation of treatment?

   ☐ Yes ☐ No

   Please provide the date of the most recent check: _____

6. Has the practitioner ordered and reviewed a random urine drug screen at least every six months?

   ☐ Yes ☐ No

   Please provide the date of the most recent check: _____

7. 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

(Form continued on next page.)

Member's Last Name:

Member's First Name:

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

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

_____

_____

_____

_____

9. 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 the Department of Medical Assistance Services.

The completed form may be faxed to **800-922-3986**, phoned to **800-424-4524 (TTY 711)**, or mailed to:

Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
11013 West Broad Street
Glen Allen, VA 23060