

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: _____

<u>Drug Name</u> (List one drug per form)	<u>Strength</u>	<u>Dosage Instructions</u>	<u>Days Supply</u>	<u>Quantity</u>	<u>Refills</u>
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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:

<u>Medication</u>	<u>Dates of use</u>	<u>Reason for Discontinuing</u>
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.*