Print Form Reset Form

FLORIDA MEDICAID PRIOR AUTHORIZATION

Stimulants and Strattera (<6 years of age)

Please select all that apply:

☐ **High-dose stimulant** ☐ **Long-acting stimulant** ☐ **Strattera**

Maximum length of approval = 6 months or less

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

☐ **New** ☐ **Continuation:** ☐ Same dose ☐ Increase ☐ Decrease **Is child in state custody care?** ☐ No ☐ Yes

Drug: _____ **Dose:** _____ **Frequency:** _____ **Quantity:** _____

Request ____months therapy **Diagnosis:** ☐ ADHD ☐ Other_____**Target Symptoms**: _____

Comorbid Medical and Psychiatric Diagnoses:_____

Height: _____ **in / cm** **Weight:** _____ **lbs /kgs** **Blood Pressure:** _____ **Pulse:** _____

BMI% _____ **History of cardiovascular disease?** ☐ No ☐ Yes; **If yes,** ☐ **patient, or** ☐ **family**

Previous Behavioral Interventions *(duration with date of initiation; if discontinued, include date and reason):* _____

_____

_____

Previous Medication Therapy *(include drug name, dose, trial duration, and reason for discontinuation):* _____

_____

_____

List other medications to be taken with the requested stimulant medication or Strattera: _____

_____

_____

Does the patient swallow medications whole *(e.g., necessary for Concerta and Strattera)*? ☐ **Yes** ☐ **No**

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

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727

University of South Florida, School of Medicine, Department of Psychiatry

USF Child Psychiatrist Review:

I do not recommend approval _____ I recommend approval for _____ months

USF Child Psychiatrist Signature:_____ Date: _____