

MEDICATION PRIOR AUTHORIZATION REQUEST FORM FAX this completed form to

OR Mail request to: Pharmacy Services Prior Authorization Dept. 5 River Park Place East, Suite 210 | Fresno, CA 93720

to request a 72-hour supply of medication.

Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

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.

| Red | Recipient's Medicaid ID# Date of Birth (MM/DD/YYYY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--------|-------|----------|----------|-------|-------|--------------|------------------|-------|--------------|--------|-------|---------|-------|-------|-----------|--------|-------|------------------|-------|-------|-------|--------|-------|------|-------|------|---|
| | | | | | | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | |
| Recipient's Full Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ket | ipiei | 11.51 | uii i | vaiiie | <i>;</i> | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prescriber's Full Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pre | scrib | er's | NPI | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <u> </u> | _ | | <u> </u> | <u> </u> | | | | | | | | | | | | | _ | | _ | | | | | | | | | |
| Prescriber Phone Number | | | | | | | | Prescriber F | | | | | | | | er F | ax N | umb | er | |] | | | | | | | | |
| | | | _ | | | | - | | | | | | | | | | | | | | - | | | | - | | | | |
| <u> </u> | lew | | Con | tinu | atior | n: 🗆 |] Sa | me d | dose | | Incr | ease | e [|] De | crea | se | | ls d | child | in s | state | cus | stod | у са | re? | □ N | No [|] Ye | s |
| Drug: | | | | | | | | D | Dose: Frequency: | | | | | | | | Quantity: | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | _ | _ | | | | | | | | | - | | | |
| Kec | lues | τ | m | onth | s tne | erapy | וט | agn | osis: | Ш. | ADH | ט ב | _ Otr | ner | | | | _ı arç | get a | sym _. | pton | ns: _ | | | | | | | |
| Comorbid Medical and Psychiatric Diagnoses: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height: in / cm Weight: | | | | | | | | | lbs /kgs | | | | | | | | | Pulse: | | | | | | | | | | | |
| DM | 10/ | | | | 11: | -1 | | | l: | | | J: | | | Nia | | l V. | . 14 | : | | l D- | 4:4 | | | | :1 | | | |
| | | | | | | - | | | liova | | | | | | | | | | - | | | | | | | • | | | |
| Previous Behavioral Interventions (Duration with date of initiation; if discontinued, include date and reason): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pre | viou | ıs M | edic | atio | n Th | erap | oy (/ | nclu | de dr | ug r | name | e, do | se, i | trial (| dura | tion, | and | reas | son | for d | iscoi | ntinu | atior | n): _ | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Lis | t oth | ner n | nedi | catio | ons t | to be | e tak | en v | vith t | the i | requ | iesto | ed st | timu | lant | med | dica | tion | or S | Strat | tera | : | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do | es th | ne pa | atier | ıt sw | allo | w m | edic | atio | ns w | hol | e (e. | .g., r | nece: | ssar | y for | Con | cert | a an | d St | ratte | ra)? | |] Ye | s | | No | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pre | scri | ber' | s Si | gnat | ure: | | | | | | | Date: | | | | | | | | | | | | | | | | | |
| | | | | | | | - | | medi | | | • | • | _ | | | | | | | ent c | hart | note | es), a | nd tl | he m | ost r | ecen | t |
| cop | ies c | ot rel | ated | iabs | . The | e pro | vide | r mu | st ret | aın (| copi | es of | all c | ocu | ment | tatio | n for | tive | year | s. | | | | | | | | | |

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.