

FLORIDA MEDICAID PRIOR AUTHORIZATION

Stimulants and Strattera (<6 years of age)

Please select all that apply:

High-dose stimulant Long-ac

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)							Y)				_								
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Ket	Recipient's Full Name																												
Prescriber's Full Name																													
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Prescriber Phone Number									ļ		Presc								criber Fax Number										
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□ New □ Continuation: □ Same dose □ Increase □ Decrease Is child in state custody care? □ No □ Yes															s														
Drug:)ose	e: Frequency:								Quantity:												
Requestmonths therapy																													
Comorbid Medical and Psychiatric Diagnoses:																													
Height: in / cm Weight:									lbs /kgs Blood Pressur								ssure: 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):																													
Lis	t otł	ner n	nedi	catio	ons	to be	e tak	en ۱	with	the	requ	uest	ed s	timu	ılant	me	dica	tion	or S	Strat	tera	:							
Does the patient swallow medications whole (e.g., necessary for Concerta and Strattera)? ☐ Yes ☐ No																													
Pre	scri	ber'	s Sig	gnat	ure:									Date:															
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Mail or Fax Information to:

Fax: 877-614-1078

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