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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's NPI

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: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to:
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