

STIMULANTS AND RELATED AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)



Keystone First

PERFORMSMR_X
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pages:
Name of office contact:		Contact's phone number:
		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:		Phone:

PRESCRIBER INFORMATION

Prescriber name:		
Specialty:	NPI:	State license #:
Street address:		
Suite #:	City/state/zip:	
Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:		Strength:	
Dosage form (tablet, ODT, suspension, etc.):	Dose/directions:	Quantity:	# months requested:
Diagnosis (submit documentation):		Diagnosis code (required):	

INITIAL REQUESTS

Has the beneficiary been taking the requested medication within the past 90 days?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
For a non-preferred drug: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred drugs in this class that are approved or medically accepted for treatment of the beneficiary's condition? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.	<input type="checkbox"/> Yes <i>List preferred medications tried:</i> <input type="checkbox"/> No

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

<input type="checkbox"/> For an analeptic Stimulants and Related Agents (e.g., Provigil, Nuvigil, Sunosi, Wakix) <input type="checkbox"/> Is <u>not</u> receiving concurrent treatment with sedative/hypnotic medications <input type="checkbox"/> Is receiving concurrent treatment with sedative/hypnotic medications — reason: _____
<input type="checkbox"/> For the treatment of narcolepsy: <input type="checkbox"/> Has a diagnosis of narcolepsy that is consistent with current International Classification of Sleep Disorders criteria (e.g., MSLT, overnight PSG, hypocretin-1 concentration, clinical assessment, etc.)
<input type="checkbox"/> For the treatment of shift work sleep disorder: <input type="checkbox"/> Has a diagnosis of shift work sleep disorder that is consistent with current International Classification of Sleep Disorders criteria (e.g., shift work schedule, sleep log and actigraphy monitoring, other causes ruled out, clinical assessment, etc.)
<input type="checkbox"/> For the treatment of obstructive sleep apnea/hypopnea syndrome (OSAHS): <input type="checkbox"/> Has a diagnosis of OSAHS that is consistent with current International Classification of Sleep Disorders criteria (e.g., overnight PSG, out-of-center sleep testing, associated medical or psychiatric disorders, clinical assessment, etc.) <input type="checkbox"/> Tried and failed continuous positive airway pressure (CPAP) while adherent to treatment to resolve daytime sleepiness demonstrated by: <input type="checkbox"/> Epworth Sleepiness Scale >10 <input type="checkbox"/> Multiple sleep latency test (MSLT) <8 minutes <input type="checkbox"/> Cannot use CPAP — reason: _____ <input type="checkbox"/> Tried and failed an oral appliance for OSAHS to resolve daytime sleepiness
<input type="checkbox"/> For the treatment of fatigue related to multiple sclerosis: <input type="checkbox"/> Is currently receiving treatment for MS <input type="checkbox"/> Is not receiving treatment for MS — reason: _____
<input type="checkbox"/> For a child <4 years of age: <input type="checkbox"/> Is prescribed the requested medication AND had a comprehensive evaluation by or in consultation with one of the following specialists: <input type="checkbox"/> pediatric neurologist <input type="checkbox"/> child/adolescent psychiatrist <input type="checkbox"/> child development pediatrician

INITIAL REQUESTS (continued)

- ☐ **For a beneficiary ≥ 18 years of age:**
- ☐ **For the treatment of ADHD:**
- ☐ Has a diagnosis of ADHD that is consistent with current DSM criteria
- ☐ **For the treatment of narcolepsy:**
- ☐ Has a diagnosis of narcolepsy consistent with current International Classification of Sleep Disorders criteria (e.g., MSLT, overnight PSG, CSF hypocretin-1 concentration, clinical assessment)
- ☐ **For the treatment of binge eating disorder:**
- ☐ Has a diagnosis of moderate to severe binge eating disorder that is consistent with the current DSM criteria
- ☐ Tried and failed (or cannot try) SSRIs (unless beneficiary has comorbid ADD or ADHD)
- ☐ Tried and failed (or cannot try) topiramate (unless beneficiary has comorbid ADD or ADHD)
- ☐ Was referred for cognitive behavioral therapy or other psychotherapy
- ☐ **For a stimulant agent:**
- ☐ Was assessed for potential risk of misuse, abuse, and/or addiction based on family and social history
- ☐ Was educated regarding the potential adverse effects of stimulants, including the risk of misuse, abuse, and addiction
- ☐ **For a beneficiary with a history of substance dependency, abuse, or diversion:**
- ☐ Has results of a recent UDS for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

RENEWAL REQUESTS

Has the beneficiary experienced a positive clinical response since starting the requested medication?	<input type="checkbox"/> Yes <i>Submit documentation</i>
	<input type="checkbox"/> No
For a non-preferred analeptic Stimulant and Related Agent: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred drugs in this class that are approved or medically accepted for treatment of the beneficiary's condition?	<input type="checkbox"/> Yes List preferred medications tried:
	<input type="checkbox"/> No _____
Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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