

Michigan Department of Health and Human Services (MDHHS)
Prior Authorization Request
Stimulant Therapy for Diagnoses Other Than ADHD

All information addressed on this form must be provided for consideration of approval. Incomplete requests will not be considered for approval and will be returned. Completed requests may be resubmitted at any time.

Beneficiary Information

LAST NAME:

FIRST NAME:

MEDICAID NUMBER:

DATE OF BIRTH: - -

GENDER: MALE FEMALE

Prescriber Information

LAST NAME:

FIRST NAME:

PLEASE SELECT ONE: MD PA NP DO

OTHER: _____

SPECIALTY: Psychiatry Neurology Oncology Sleep Medicine Family Practice (FP)/Internal Medicine (IM)
 Pediatrics Physical Medicine and Rehab (Physiatry) Other: _____

NPI NUMBER:

DEA #: -

DEA # EXP: - -

PHONE NUMBER: - -

FAX NUMBER: - -

Person Completing Form

LAST NAME:

FIRST NAME:

TITLE:

PHONE NUMBER: - -

FAX NUMBER: - -

DATE: _____ REQUESTED START DATE: _____

Pharmacy

NAME:

PHONE NUMBER: - -

FAX NUMBER: - -

NAME OF MEDICATION BEING REQUESTED:

| Drug Name | Strength | Dosing | Duration of Treatment | Diagnosis |
|-----------|----------|--------|-----------------------|-----------|
| | | | | |

NAME OF PREVIOUS MEDICATIONS TRIED FOR THIS CONDITION:

| Drug Name | Strength | Directions | Dates | Reason for Failure |
|-----------|----------|------------|-------|--------------------|
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WORKING DIAGNOSIS (INTENDED USE FOR THIS MEDICATION):

Sleep disorders

- Narcolepsy
- Obstructive Sleep Apnea [OSA] / Obstructive Sleep Apnea Syndrome [OSAS]:
 - Has the diagnosis been confirmed by a sleep study?
 - Has CPAP therapy been maximized?
- Shift Work Sleep Disorder [SWSD] (Provigil® & Nuvigil® Only): Requests for any other medication must include supporting documentation. Requests must address all of the following:
 - Have opportunities for maximizing sleep been addressed?
 - Has obtaining enough sleep been emphasized?
 - Has counseling regarding appropriate sleep hygiene been provided? Document patient-specific details.
 - Can work hours be adjusted?
 - Does the shift vacillate between overnight and daytime hours?
 - What specific effects other than 'feeling sleepy' or 'fatigue' are being experienced?

Cancer Related Fatigue: Request from Oncologist and the patient must be undergoing active chemotherapy and/or radiation therapy

Adjunct treatment for psychiatric/developmental health disorder:

- Major Depressive Disorder [MDD]: Must be made by a Psychiatrist or a Community Mental Health (CMH) Medical Director and must include a list of current antidepressant medications
- Bipolar Disorder [BPD]: Must be made by a Psychiatrist
- Autism Spectrum Disorder: Must be made by a Psychiatrist or Neurologist

Traumatic Brain Injury [TBI]

Binge-Eating Disorder (Vyvanse® Only): Must be made by a Psychiatrist or be accompanied by a report performed by a Psychologist or Social Worker documenting confirmation of the diagnosis

Multiple Sclerosis Related Fatigue

Myotonic Dystrophy (Provigil® Only)

Other: _____

ADDITIONAL INFORMATION:

1. For ADHD, please refer to the **Therapy for ADD/ADHD Recipients Over Age 17 Years** Prior Authorization Request form.
2. Include a current progress note highlighting anticipated clinical benefit and medical necessity to use this medication for this purpose. Include relevant diagnostic and consultation reports that support medical necessity. For diagnoses listed as "other" above, please include supporting guidelines and/or literature to substantiate the request.
3. Has the prescribing physician named above verified medication usage by obtaining and reviewing a MAPS report (<https://michigan.pmpaware.net/login>)? Yes No
4. Is the patient taking concurrent sedating medication? Yes No

If the answer to question 4 is 'yes', list all concurrent sedating medications.

| Drug Name | Strength | Dosing | Duration of Treatment | Diagnosis |
|-----------|----------|--------|-----------------------|-----------|
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