

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR STIMULANTS AND RELATED AGENTS**

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions, F-11097A.

Pharmacy providers are required to have a completed PA/PDL for Stimulants and Related Agents form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call ForwardHealth at (800) 947-9627 with questions.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — PRESCRIPTION INFORMATION**

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Directions for Use
8. Name — Prescriber	9. National Provider Identifier (NPI)
10. Address — Prescriber (Street, City, State, ZIP+4 Code)	
11. Telephone Number — Prescriber	

**SECTION III — CLINICAL INFORMATION FOR STIMULANTS AND RELATED AGENTS**

12. Diagnosis Code and Description

**SECTION IIIA — CLINICAL INFORMATION FOR NON-PREFERRED STIMULANTS**

13. Has the member experienced treatment failures or clinically significant adverse drug reactions with two preferred stimulants?  Yes  No

If yes, list the preferred stimulants, specific details about the treatment failures or adverse drug reactions, and the approximate dates the preferred drugs were taken in the space below.

**SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA**

14. Has the member experienced treatment failures or clinically significant adverse drug reactions with two preferred stimulants?  Yes  No

If yes, list the preferred stimulants, specific details about the treatment failures or adverse drug reactions, and the approximate dates the preferred drugs were taken in the space below.

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**SECTION IIIB — CLINICAL INFORMATION FOR STRATTERA (Continued)**

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15. Does the member have a medical condition(s) (e.g., Tourette's syndrome, obsessive compulsive disorder) that prevents the use of a preferred stimulant?  Yes  No

If yes, list the medical condition(s) in the space below.

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16. Does the member have a medical history of substance abuse or misuse?  Yes  No

If yes, explain in the space below.

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17. Does the member have a serious risk of diversion?  Yes  No

If yes, explain in the space below.

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**SECTION IV — AUTHORIZED SIGNATURE**

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18. SIGNATURE — Prescriber

19. Date Signed

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**SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA**

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20. National Drug Code (11 Digits)

21. Days' Supply Requested (Up to 365 Days)

22. NPI

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23. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

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24. Patient Location (Use patient location code "0" [Not Specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)

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25. Assigned PA Number

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26. Grant Date

27. Expiration Date

28. Number of Days Approved

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**SECTION VI — ADDITIONAL INFORMATION**

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29. Include any additional diagnostic and clinical information explaining the need for the drug requested.

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