



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#

Grid for Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Request type: 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.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593

02.15.2024

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