



WVCHIP
WV Children's Health Insurance Program
ADDM Pharmacy Prior Approval Program



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Morgantown, WV 26505

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Attention Deficit Disorder Medication Prior Approval Request Form

I. Patient and Medication Information

Patient Name (Last) (First) (MI)	Patient's WVCHIP Identification #:	Patient's Date of Birth
Requested Medication Name:	Dose	Directions
		Patients Current Age

II. Prescriber Information

Prescribing Practitioner's Name (Last)	(First)	(MI)	(Specialty)
Practitioner Address: (Street)	(City)	(State)	(Zip)
Practitioner DEA Number	Return Phone #	Return FAX #	

III. Please answer each of the following questions for your request.

1. What is the diagnosis for which this drug is being prescribed?

- ☐ Attention Deficit Disorder (ADD) ☐ ADHD, Predominantly Inattentive Type (314.00)
- ☐ ADHD, Predominantly Hyperactive-Impulse Type (314.01) ☐ ADHD, Combined Type (314.01)
- ☐ Other – Please Document:

2. Which set of criteria was used to determine the diagnosis? Check all that apply

- ☐ History/Physical
- ☐ DSM-IV Criteria
- ☐ Research Diagnostic Criteria: Preschool Age (AACAP Task Force on Research Diagnostic Criteria: Infancy Preschool Age, 2003)
- ☐ Diagnostic Criteria: 0Y3R (Zero to Three Diagnostic Classification Task Force, 2005)
- ☐ Other, please document, including name of diagnostic tool

3. Has an assessment been completed by the prescribing physician within the last year? ☐ Yes ☐ No

(Examples of credentialed professionals are physician, psychiatrist, psychologist, social worker trained and experienced with Attention Disorders, or an ADHD Coach Certified by the Institute for the Advancement of AD/HD Coaching (IAAC))

4. Has an assessment been completed by the prescribing physician within the last year? ☐ Yes ☐ NO

5. What date was the assessment performed? _____

Practitioner Signature: _____

(If a signature stamp is used, then the prescribing Practitioner must initial the signature, signatures by agents of the Practitioner are not acceptable)

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