



**WV Public Employees Insurance Agency
WV Children's Health Insurance Program**
Pharmacy Prior Approval Program
PO Box 9511 HSCN, WVU School of Pharmacy
Morgantown, WV 26505



Phone 1-800-847-3859

FAX: 1-800-531-7787

Attention Deficit Disorder Medication Prior Approval Request Form

I. Patient and Medication Information

Patient Name (Last) (First) (MI)	Patient's PEIA Identification #:	Patient's Date of Birth
Requested Medication Name:	Dose	Directions
		Patient's 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 #)

IV. 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 name diagnostic tool:

3. Has a treatment plan been developed by the prescribing physician or other credentialed professional?

(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))

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

4. Has an assessment been completed by the prescribing physician within the last year?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

5. What date was the assessment performed?

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

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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