



**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**

<b>Patient Name</b> (Last) (First) (MI)	<b>Patient's PEIA Identification #:</b>	<b>Patient's Date of Birth</b>
<b>Requested Medication Name:</b>	<b>Dose</b>	<b>Directions</b>
		<b>Patient's Current Age</b>

**II. Prescriber Information**

<b>Prescribing Practitioner's Name</b> (Last) (First) (MI) (Specialty)
<b>Practitioner Address:</b> (Street) (City) (State) (Zip)
<b>Practitioner DEA Number</b> (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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