Neighborhood Health Plan of Rhode Island Prior Authorization Form Non-Stimulant ADHD Agents – Strattera® (atomoxetine) and Intuniv® (guanfacine)

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of **Strattera® (atomoxetine) or Intuniv® (guanfacine)**. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	**Member ID Number:** (required)
Member Date of Birth: (required) / /	**Member Sex:** M F (Circle One)
Prescriber Name: (required)	**Contact Person at Office:**
Office Phone number: (required) ( ) -	**Office Fax Number:** (required) ( ) -

Drug ______________________ **Directions of use:** ____________________________________

Quantity______ **Duration of Treatment** ______________

Neighborhood's criteria for approval of Strattera® or Intuniv® requires that the patient:

- **Has failed to achieve an adequate clinical outcome or experienced side effects/intolerance following a recent trial of an appropriate dose and duration of therapy using at least 2 generic stimulants including at least 1 methylphenidate product and 1 amphetamine product (of which 1 must be a long acting formulation) OR**
- **Is not a candidate for treatment with a stimulant due to documented medical or co morbid condition.**
- **For Intuniv® only - Has failed to achieve an adequate clinical outcome or experienced side effects/intolerance following a recent trial using generic guanfacine**

Please Check all that apply:

☐ Patient has failed appropriately dosed recent trial with at least two of the following generic agents (**1 of which must be a long acting formulation**):

☐ Methylphenidate IR	Date_______	circle one	Inadequate response	Side effect
☐ Methylphenidate ER/LA	Date_______	circle one	Inadequate response	Side effect
☐ Amphetamine IR agent	Date_______	circle one	Inadequate response	Side effect
☐ Amphetamine XR/LA agent	Date_______	circle one	Inadequate response	Side effect

☐ Patient is not a candidate for treatment with a stimulant due to the following documented medical or co morbid condition(s) (check all that apply).

☐ Glaucoma	☐ Cardiovascular disease_______________
☐ Use of MAO-I within past 14 days	☐ Pre-existing Psychosis
☐ Tourette's syndrome or tics	☐ Bipolar disorder
☐ Other________________________________	☐ Seizure disorder

☐ **For Intuniv® Only** - Patient has failed appropriately dosed recent trial with generic guanfacine.

Date_________ circle one Inadequate response Side effect

Prescriber Signature__________________________ **NPI** __________________ **Date**________

Completed forms should be faxed to: Customer Service Department (866) 423-0945