

**ADHD Medications in Children < 6 years of age  
Prior Authorization Request Form**

If the child is a ward of DCFS, has consent to prescribe this psychotropic medication been obtained from DCFS? **If not**, the prescriber must obtain consent from DCFS using the Psychotropic Medication Request form at [http://www.state.il.us/DCFS/library/com\\_communications\\_forms.shtml](http://www.state.il.us/DCFS/library/com_communications_forms.shtml) before prescribing any psychotropic medications.

**Fax completed form:** 217-524-7264

**Additional information:** 800-252-8942

**To check status:** 800-642-7588

**Patient Information:**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Nine-Digit HFS ID Number: \_\_\_\_\_

**Prescriber Information:**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Specialty: \_\_\_\_\_

Provider #: \_\_\_\_\_

**Contact person for this request:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Clinical Information**

1. Medication requested: \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

2. Indication: \_\_\_\_\_

3. Please list other psychiatric illnesses with which patient has been diagnosed: \_\_\_\_\_

4. Patient's Weight: \_\_\_\_\_ (kg) Age: \_\_\_\_\_ (yrs) Physician-level review will be initiated if patient is < 4 yrs old

5. Please indicate settings where the patient's symptoms are present:

**Home:**  Yes  No **Daycare/preschool:**  Yes  No  Patient does not attend daycare/ preschool

6. Check **ALL** that apply.

Inattention present for:  less than 6 months  greater than 6 months

Hyperactivity-impulsivity present for:  less than 6 months  greater than 6 months

Other behavioral symptoms (include duration) \_\_\_\_\_

7. Does patient have any of the following? (Check **ALL** that apply) [Physician-level review will be initiated]

Oppositional defiant disorder  Conduct disorder  Anxiety disorder  Developmental delay

Pervasive depression  Dysphoric mood  Uncontrolled anger  Psychosis

8. Please list **ALL** previous drug and non-drug therapy (including psychosocial interventions) for **ADHD** (claims history will also be used for medication list): \_\_\_\_\_

9. Is patient being discharged from hospital or institution on this medication?  Yes  No

Other Pertinent Information: \_\_\_\_\_

A **Child and Adolescent Behavior Health Consultation Program** is now available for providers who wish to consult with a child and adolescent psychiatrist regarding their patients. This service is available at no charge. The hotline number is: 1-866-986-2778. The website is: [www.psych.uic.edu/DOCASSIST](http://www.psych.uic.edu/DOCASSIST)

Prescriber or designee signature: \_\_\_\_\_

Date: \_\_\_\_\_