**PA02 - CNS STIMULANTS**
**NOT required for recipients less than 21 years of age.**

**Executive Office of Health & Human Services**
**PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)**
**Gainwell Technologies ATTN: PHARMACIST**
**301 Metro Center Blvd., 3rd Floor ▪ Warwick, RI 02886 ▪ FAX (401) 784-3889**

CLIENT NAME: _____ DOB: ___/___/_____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

_____

OFFICE PHONE NUMBER (  ) _____ FAX NUMBER (  ) _____

---

DRUG REQUESTED: _____ QTY / FILL _____(NO REFILLS ALLOWED)

***INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD10 CODE.***

___ DOES THE PATIENT HAVE A DIAGNOSIS OF NARCOLEPSY? ICD10 CODE_____

___DOES THE PATIENT HAVE A DIAGNOSIS OF ATTENTION DEFICIT DISORDER? ICD10 CODE_____

___DOES THE PATIENT HAVE A DIAGNOSIS OF ATTENTION DEFICIT HYPERACTIVITY DISORDER? ICD10 CODE_____

___DOES THE PATIENT HAVE A DIAGNOSIS OF MAJOR DEPRESSIVE AFFECTIVE DISORDER? ICD10 CODE_____

___DOES THE PATIENT HAVE A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER? ICD10 CODE_____

___DOES THE PATIENT HAVE A DIAGNOSIS OF DEPRESSIVE DISORDER? ICD10 CODE_____

___OTHER_____ ICD10 CODE_____

COMMENTS: _____

_____

_____

_____

**PRESCRIBER SIGNATURE** _____**DATE** _____

***BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.***

**CONTACT GAINWELL TECHNOLOGIES CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100**

FOR STATE USE ONLY:

APPROVAL: _____YES _____NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____TO _____

Revised 10.2020