State of Illinois
Department of Healthcare and Family Services

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** before prescribing any psychotropic medications.

Fax completed form: **217-524-7264** Additional information: **800-252-8942**

Patient Information:

Name: _____

DOB: _____

Patient's weight (kg): _____

Nine-Digit HFS ID Number: _____

Prescriber Information:

Name: _____

Phone: _____ Fax: _____

Specialty: _____

NPI #: _____

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. Please indicate settings where the patient's symptoms are present:
   Home: ☐ Yes ☐ No **Daycare/preschool:** ☐ Yes ☐ No ☐ Not applicable
5. 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) _____
6. Does patient have any of the following? (Check **ALL** that apply)
   - ☐ Oppositional defiant disorder ☐ Conduct disorder ☐ Anxiety disorder ☐ Developmental delay
   - ☐ Pervasive depression ☐ Dysphoric mood ☐ Uncontrolled anger ☐ Psychosis
7. Please list **ALL** previous drug therapy for **ADHD**: _____
8. Please list **ALL** previous non-drug therapy (including psychosocial interventions) for **ADHD**: _____
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

Prescriber or designee signature: _____ Date: _____

Print Form