

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

CNS Stimulants for Adults Age 19 and Above

- A review of written documentation to substantiate a complete, appropriate, and covered diagnosis for both new starts and members currently receiving any CNS stimulant listed below will be required before Prior Authorization approval. **Prescribing history alone WILL NOT meet criteria for approval.**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Request is being submitted for **BRAND**

Request is being submitted for **GENERIC**

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight (if applicable): _____ Date weight obtained: _____

- Will the member be discontinuing a previously prescribed central nervous system (CNS) stimulant medication if approved for requested medication?

Yes **OR** No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ Effective date: _____

Medication to be initiated: _____ Effective date: _____

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DRUG(S) REQUESTED: Check applicable drug(s) below. Box(es) **must** be checked to qualify, or authorization process will be delayed.

| | | | |
|---|---|--|--|
| <input type="checkbox"/> Adhansia XR [®] | <input type="checkbox"/> Adzenys XR-ODT [®] <input type="checkbox"/> Adzenys ER [®] Suspension | <input type="checkbox"/> amphetamine/ dextroamphetamine (Adderall [®]) | <input type="checkbox"/> amphetamine/ dextroamphetamine ER (Adderall XR [®]) |
| <input type="checkbox"/> amphetamine ER ODT (Adzenys XR ABA) | <input type="checkbox"/> amphetamine sulfate (Evekeo [®]) | <input type="checkbox"/> Azstarys [®] | <input type="checkbox"/> Cotempla XR/ODT [®] |
| <input type="checkbox"/> dexmethylphenidate (Focalin [®]) | <input type="checkbox"/> dexmethylphenidate ER (Focalin XR [®]) | <input type="checkbox"/> dextroamphetamine (Dextrostat [®]) | <input type="checkbox"/> dextroamphetamine (ProCentra [®]) |
| <input type="checkbox"/> dextroamphetamine (Zenzedi [®]) | <input type="checkbox"/> dextroamphetamine ER (Dexedrine Spansule [®]) | <input type="checkbox"/> Dyanavel [®] XR Suspension <input type="checkbox"/> Dyanavel [®] XR Chewable Tablets | <input type="checkbox"/> Evekeo ODT [®] |
| <input type="checkbox"/> Jornay PM [®] | <input type="checkbox"/> lisdexamfetamine (Vyvanse [®]) | <input type="checkbox"/> methamphetamine (Desoxyn [®]) | <input type="checkbox"/> methylphenidate ER (Aptensio XR [®]) |
| <input type="checkbox"/> methylphenidate ER (Concerta [®]) | <input type="checkbox"/> methylphenidate TD Patch (Daytrana [®]) | <input type="checkbox"/> methylphenidate ER (Metadate ER [®] / Ritalin SR [®]) | <input type="checkbox"/> methylphenidate (Methylin [®] /Ritalin [®]) |
| <input type="checkbox"/> methylphenidate LA (Ritalin LA [®]) | <input type="checkbox"/> methylphenidate CD (Metadate CD [®]) | <input type="checkbox"/> Mydayis [®] | <input type="checkbox"/> Quillichew [®] ER |
| <input type="checkbox"/> Quillivant XR [®] | <input type="checkbox"/> Xelstrym [™] (dextroamphetamine) | | |

DIAGNOSES: Check applicable diagnosis below with ICD Code and description. For ****BINGE EATING DISORDER**, obtain BED specific form, found under “Vyvanse (Binge Eating Disorder). **

- ADHD/ADD: ICD-9/10: _____ Description: _____
***please complete table below and attach/fax any documentation as requested**
- Narcolepsy: ICD-9/10: _____ Description: _____
***please attach and fax documentation (polysomnogram and MSLT results) to support diagnosis**
- Other*: ICD-9/10: _____ Description: _____
***please attach and fax documentation (i.e. chart notes, previous therapies tried) to support diagnosis**

***NON-FDA approved indications** - submit **two (2)** peer reviewed clinical studies documenting the safety and efficacy of the specified drug for that particular indication.

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Name of Diagnosing Prescriber: _____ Date of Diagnosis: _____

If the member was diagnosed by another prescriber as either a child or an adult, please submit the name of the prescriber, the date of diagnosis, and copies of testing and chart notes detailing signs and symptoms. Include any additional evaluation done as the prescribing physician in the table below or as a faxed attachment.

- Did the prescriber use the **Diagnostic and Statistical Manual of Mental Disorders, 5TH Edition** and determine that criteria have been met (**including documentation of impairment in more than one major setting**) to make the diagnosis of ADHD?
 - Yes
 - No
- The diagnosis has been verified using a standardized rating scale, patient interview, or psychological evaluation (**NOTE: THE PATIENT-SPECIFIC DSM SYMPTOMS, CRITERIA, PSYCHOLOGICAL EVALUATION, AND/OR STANDARDIZED RATING SCALE USED TO MAKE OR VERIFY THE DIAGNOSIS MUST BE SUBMITTED WITH THIS FORM FOR APPROVAL**)
 - Adult Self-Report Scale- V1.1
 - Member Interview
 - Wender Adult ADHD Rating Scale
 - Psychological Evaluation
 - Other: _____

If requesting Brand/ABA or generic/AGA when applicable for **Adhansia XR[®], Adzenys[®], Aptensio XR[®], Azstarys[®], Cotelpla XR ODT[®], Daytrana[®], Dyanavel[®] XR, Evekeo[®]/Evekeo ODT[®], Jornay PM[®], Mydayis[®], Quillichew[®] ER, Quillivant[®] XR or Xelstrym[™]**, the following criteria **MUST** be met:

- Member must have tried and failed **30 days of therapy** with **three (3)** of the following generic stimulant medications – medication trial **MUST** include an amphetamine-based stimulant **AND** a methylphenidate-based stimulant (**verified by chart notes and/or pharmacy paid claims**):
 - Amphetamine-based stimulants:** (select all that apply)
 - amphetamine-dextroamphetamine IR/ER (generic Adderall/Adderall XR[®])
 - dextroamphetamine IR/SR (generic Dextrostat[®]/Procentra[®]/Zenedi[®]/Dexedrine[®] IR/ER)
 - lisdexamfetamine (generic Vyvanse[®])
 - Methylphenidate-based stimulants:** (select all that apply)
 - dexmethylphenidate IR/ER (generic Focalin[®]/Focalin XR[®])
 - methylphenidate IR/ER (generic Ritalin[®]/Methylin[®]/Ritalin SR[®]/Ritalin LA[®]/Concerta[®]/ Metadate CD[®]/Metadate ER[®])

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Please be aware if this request is for a dose that **EXCEEDS** Sentara Health's Maximum Daily Dosage Limits, a second prior authorization request will need to be submitted for dosage approval. The correct form can be downloaded from <http://providers.sentarahealthplans.com/>

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmac-y paid claims or submitted chart notes.