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: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

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

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – provide therapy start date: _____

- 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.

❑ **Adhansia XR®**	❑ **Adzenys XR-ODT®** ❑ **Adzenys ER® Suspension**	❑ **amphetamine/ dextroamphetamine** (Adderall®)	❑ **amphetamine/ dextroamphetamine ER** (Adderall XR®)
❑ **amphetamine ER ODT** (Adzenys XR)	❑ **amphetamine sulfate** (Evekeo®)	❑ **Azstarys®**	❑ **Cotempla XR – ODT®**
❑ **dexmethylphenidate** (Focalin®)	❑ **dexmethylphenidate ER** (Focalin XR®)	❑ **dextroamphetamine** (Dextrostat®)	❑ **dextroamphetamine** (ProCentra®)
❑ **dextroamphetamine** (Zenzedi®)	❑ **dextroamphetamine ER** (Dexedrine Spansule®)	❑ **Dyanavel® XR Suspension** ❑ **Dyanavel® XR Chewable Tablets**	❑ **Evekeo ODT®**
❑ **Jornay PM®**	❑ **lisdexamfetamine** (Vyvanse®)	❑ **methamphetamine** (Desoxyn®)	❑ **methylphenidate** (Methylin®/Ritalin®)
❑ **methylphenidate LA** (Ritalin LA®)	❑ **methylphenidate CD** (Metadate CD®)	❑ **methylphenidate ER** (Aptensio XR®)	❑ **methylphenidate ER** (Concerta®)
❑ **methylphenidate ER** (Metadate ER®/ Ritalin SR®)	❑ **methylphenidate ER ODT** (Cotempla XR – ODT® ABA)	❑ **methylphenidate TD Patch** (Daytrana®)	❑ **Mydayis®**
❑ **Quillichew® ER**	❑ **Quillivant XR®**	❑ **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.**

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.

Authorization Length: 12 months

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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
  - ❑ Adult Self-Report Scale- V1.1 **(must submit)**
  - ❑ Member Interview **(must submit)**
  - ❑ Wender Adult ADHD Rating Scale **(must submit)**
  - ❑ Psychological Evaluation **(must submit)**
  - ❑ Other: _____ **(must submit)**

If requesting Brand/ABA or generic/AGA when applicable for **Adhansia XR®, Adzenys®, Aptensio XR®, Azstarys®, Cotempla 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®/Zenzedi®/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®

Please be aware if this request is for a dose that EXCEEDS AvMed's maximum quantity limits, a second prior authorization request will need to be submitted for quantity limit exception approval. The correct form can be downloaded from: https://www.avmed.org/en/forms/provider . Providers can also complete the following section if quantity limit exception for the requested stimulant therapy and/or regimen is required.

- ❑ Requested dose exceeds at least **ONE** of the following **(check all that apply)**:
  - ❑ Maximum FDA approved labeling for the requested indication
  - ❑ AvMed allowable quantity limit
  - ❑ Other: _____

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- ❑ Provider must submit documentation for each of the following, **IF applicable**:
  - ❑ Provider has submitted documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature) **(attach additional pages if necessary)**
  - ❑ Member has tried and failed all available alternative dosage strength(s) for the requested drug that can be obtained within the SHP allowable quantity limits unless no alternative dosage strength is available **(submit documentation of treatment failure)**
  - ❑ Member has tried and failed FDA approved dose and/or frequency for the requested indication **(submit documentation of treatment failure)**

    [**EXAMPLE:** The requested dosing regimen (Trintellix 5 mg tablet taken daily along with Trintellix 10 mg tablet) is not covered by the plan. The plan covers Trintellix 10 mg tablet taken as 1 tablet daily or Trintellix 20 mg tablet taken as 1 tablet daily. According to the Trintellix prescribing information, the recommended starting dose is 10 mg administered orally once daily without regard to meals. The dose should then be increased to 20 mg/day, as tolerated. Provider must submit documentation that the member has had an unsuccessful trial of Trintellix 20 mg taken once daily.]
- ❑ Provider must document all applicable previously failed therapies for requested indication:

  _____
- ❑ Provider must submit clinical rationale for the requested quantity exceeding plan limits **(attach additional pages if necessary)**

  _____

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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 pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~7/17/2014; 1/18/2018; 9/15/2022; 2/16/2023; 7/24/2025; 9/25/2025; 5/28/2026;~~ **9/24/2026**
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