

SENTARA HEALTH PLANS

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 **1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization may be delayed.

Non-Preferred Central Nervous System (CNS) Stimulants (For all ages)

- 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 Sentara #: _____ 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: _____

(Continued on next page)

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 sulfate (Evekeo [®])	<input type="checkbox"/> Azstarys [®]
<input type="checkbox"/> Cotempla XR-ODT [®]	<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"/> methylphenidate ER (Aptensio XR [®])	<input type="checkbox"/> methylphenidate TD Patch (Daytrana [®])	<input type="checkbox"/> Mydayis [®]	<input type="checkbox"/> Quillichew [®] ER
<input type="checkbox"/> Quillivant XR [®]	<input type="checkbox"/> Xelstry [™] (dextroamphetamine)		

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.

- ☐ 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[®])

- ☐ If the member is **over the age of 18**, member **must** also meet diagnostic criteria. The prior authorization form “CNS Stimulants for Adults Age 19 and Above” can be downloaded from: <http://www.sentarahealthplans.com/providers/>

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.****