Sentara® Health Plans

BEHAVIORAL HEALTH GUIDELINE

ADULT ADHD

Guideline History

Date Approved	7/06
Date Revised	7/08; 7/10; 7/12; 10/18
Date Reviewed	7/14; 7/16, 7/18, 10/20, 10/22
Next Review Date	10/24

Key Points

- ✓ ADHD is a biologically based disorder.
- ✓ Symptoms of ADHD from childhood often continue into adulthood. Prevalence of ADHD in adults in the US is approximately 4%.
- ✓ DSM-V criteria for ADHD in adults: 5 symptoms (as opposed to 6 for children) in one domain (inattention or hyperactivity/impulsivity). Diagnosis should be based on a detailed patient history ("several symptoms present prior to age 12") and an assessment of current behavior and level of functioning ("substantial evidence of clinically significant ADHD impairment").
- ✓ ADHD in adults is associated with higher than average rates of divorce, unemployment, substance abuse, and motor vehicle accidents.
- ✓ ADHD rarely occurs alone. Common comorbidities include: mood disorders (depression and bipolar), anxiety disorders, substance use disorders, or impulse control disorders.
- ✓ Various medical conditions (thyroid disease, hepatic disease, sleep apnea) have symptoms similar to those of ADHD. Also, some medications/substances (steroids, antihistamines, anticonvulsants, caffeine, nicotine) may impact attentiveness.
- ✓ Standardized rating scales can be useful for assessing presence of symptoms and severity of impairment both for diagnostic purposes and to assess effectiveness of treatment. The ADHD Adult Self-Report Scale V1.1 (ASRS V1.1) and the Wender Adult ADHD Rating Scale are attached.
- ✓ Contraindications for stimulant use include hypertension, tachycardia, arrhythmia, bipolar disorder, severe anorexia and Tourette syndrome.
- ✓ Cognitive behavior therapy or other psychosocial treatment should be recommended as an adjunct to medication in the treatment of ADHD in adults.
- ✓ Strategies to prevent misuse or diversion of stimulants include: signing a controlled substances agreement and performing random urine drug screening to verify that the patient is taking the prescribed medication and to screen for non-prescribed or illicit drugs.

Adapted from: "Stimulants and Related Medications" Toolkit, the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/pharmacy-ed-materials.html on the Centers for Medicare & Medicaid Services (CMS) website.

Medication	Indication	Dosing Information	Other Information	Generic Availability
amphetamine/dextroamphetamine mixed salts	ADHD	**Initial dose**: 5mg once or twice a day **Maximum dose**: 40 mg per day	May increase daily dose by 5mg at weekly intervals until optimal response is achieved. Only in rare cases will it be necessary to exceed a total of 40mg per day	Yes
amphetamine/dextroamphetamine mixed salts ER	ADHD	**Recommended dose**: 20mg once per day	Patients switching from regular-release amphetamine/dextroamphetamine mixed salts may take the same total daily dose once a day.	Yes
atomoxetine	ADHD	**Initial dose**: 40mg per day **Target dose**: 80 mg per day **Maximum dose**: 100mg per day	May increase after 3 days to target dose. Dose may be further increased to 100mg per day after 2 to 4 additional weeks; dose may be given once a day in the morning or twice a day, evenly divided, in the morning and late afternoon or early evening.	Yes
dexmethylphenidate ER	ADHD	**Patients naive to methylphenidate**: **Initial dose**: 10 mg once a day; **Maximum dose**: 40 mg once a day. **Patients currently taking methylphenidate**: **Initial dose**: one-half the total daily dose of methylphenidate; **Maximum dose**: 40 mg once a day. **Patients currently taking dexmethylphenidate:** **Initial dose**: the same total daily dose of dexmethylphenidate given once a day; **Maximum dose**: 40 mg once a day	May increase daily dose by 10mg at weekly intervals. Take in the morning.	Yes
lisdexamfetamine	ADHD	**Initial dose**: 30mg once a day **Maximum dose**: 70mg once a day	May increase daily dose by 10mg or 20mg at weekly intervals. Take in the morning; afternoon doses should be avoided due to the potential to cause insomnia.	Yes
methylphenidate	ADHD	**Average dose:** 20mg to 30 mg per day **Maximum dose**: 60mg per day	May increase daily dose by 5mg or 10mg at weekly intervals; take in 2 or 3 divided doses preferably 30 to 45 minutes before meals.	Yes

Medication	Indication	Dosing Information	Other Information	Generic Availability
methylphenidate chewable tablet and solution	ADHD	**Average dose**: 20mg to 30 mg per day **Maximum dose**: 60 mg per day	May increase daily dose by 5mg or 10mg at weekly intervals; take in 2 or 3 divided doses preferably 30 to 45 minutes before meals.	Yes
methylphenidate ER (Aptensio XR[TM])	ADHD	**Initial dose**: 10mg once a day in the morning **Maximum dose**: 60mg per day	May increase dose weekly by 10mg until effective	No
methylphenidate ER (Concerta®	ADHD	**Initial dose**: 18mg or 36mg once a day **Maximum dose**: 72mg once a day	Not FDA approved for use in patients over 65 years old. May increase daily dose by 18mg at weekly intervals. Take in the morning. Consult prescribing information for converting from methylphenidate IR to Concerta.	Yes
methylphenidate ER oral suspension	ADHD	**Initial dose**: 20mg once per day **Maximum dose**: 60mg once per day	May increase daily dose by 10mg to 20mg at weekly intervals. Take in the morning.	No
methylphenidate SR	ADHD	**Dose**: the 8-hour dosage should correspond to the titrated 8-hour dosage of the methylphenidate IR formulation	Methylphenidate SR (Ritalin-SR®) tablets have a duration of action of approximately 8 hours.	Yes

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; **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 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.**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form: _____ **Strength/Quantity:** _____

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

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

❑ **Adderall XR® (BRAND PREFFERED)**	❑ **Daytrana®**	❑ **Dyanavel® XR**	❑ **methylphenidate ER (Ritalin SR®/Metadate ER®)**
❑ **amphetamine/ dextroamphetamine (Adderall®)**	❑ **dexmethylphenidate (Focalin®)**	❑ **Evekeo®/Evekeo ODT®**	❑ **methylphenidate LA (Ritalin LA®)**
❑ **Adhansia XR®**	❑ **dexmethylphenidate ER (Focalin XR®)**	❑ **Jornay PM®**	❑ **Mydayis®**
❑ **Adzenys XR-ODT® / Adzenys ER® Susp**	❑ **dextroamphetamine (Zenzedi®)**	❑ **methamphetamine (Desoxyn®)**	❑ **Quillichew® ER**
❑ **Aptensio XR®**	❑ **dextroamphetamine (ProCentra®)**	❑ **methylphenidate (Ritalin®/Methylin®)**	❑ **Quillivant XR®**
❑ **Azstarys™**	❑ **dextroamphetamine (Dextrostat®)**	❑ **methylphenidate CD (Metadate CD®)**	❑ **Relexxii™**
❑ **Cotempla XR ODT®**	❑ **dextroamphetamine ER (Dexedrine Spansule®)**	❑ **methylphenidate ER (Concerta®)**	❑ **Vyvanse®**

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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.

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.

- ❑ Existence of **at least 5** symptoms for **a minimum of 6 months**? **(indicate symptoms below)**
  - ❑ **Inattentive Symptoms**: 5 or more
  - ❑ **Hyperactive-Impulsive Symptoms**: 5 or more
  - ❑ **Combined Symptoms**: 10 or more ADHD symptoms including 5 or more inattentive symptoms **AND** 5 or more hyperactive-impulsive symptoms
- ❑ Documentation that symptoms impair or compromise normal functioning.
- ❑ Documentation that symptoms are present in **two (2) or more** settings/environments **(indicate settings)**:
  1. _____ **2.** _____
- ❑ Documentation of inattentive or hyperactive-impulsive symptoms **before the age of 12**. (**if available**, indicate source below)
  - ❑ Medical Chart/Progress Notes documenting childhood diagnosis and/or symptoms
  - ❑ School Records
  - ❑ Corroborated by a relative/friend
  - ❑ Not Available
- ❑ Symptoms are not better explained by another disorder (e.g. Schizophrenia, Mood Disorder, Anxiety Disorder, Substance Abuse, Dissociative Disorder, or Personality Disorder)

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- ❑ The diagnosis has been verified using a standardized rating scale, patient interview, or psychological evaluation
  - ❑ Adult Self-Report Scale- V1.1
  - ❑ Wender Adult ADHD Rating Scale
  - ❑ Other: _____
  - ❑ Member Interview
  - ❑ Psychological Evaluation
- ❑ **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.**

❑ If requesting **Adhansia XR®, Adzenys®, Aptensio XR®, Azstarys™, Cotempla XR ODT®, Daytrana®, Dyanavel® XR, Evekeo®/Evekeo ODT®, Jornay PM®, Mydayis®, Quillichew® ER, or Quillivant® XR:**

- Member **must** have tried and failed **30 days of therapy with:**
  - ❑ **Two (2) of the following**:

❑ amphetamine-dextroamphetamine IR (generic Adderall) or Adderall XR®	❑ dexmethylphenidate IR/ER (generic Focalin®/Focalin XR®)
❑ dextroamphetamine IR/SR (generic Dextrostat®/Procentra®/Zenzedi®/Dexedrine®)	❑ methylphenidate IR/ER (generic Ritalin®/ Ritalin SR®/Ritalin LA®/Concerta®/ Metadate CD®

AND

  - ❑ Vyvanse® (**NOT** required for Evekeo®/Evekeo ODT™)

❑ If requesting **generic** amphetamine-dextroamphetamine ER (Adderall XR®) the following criteria must be met:

- If requesting generic amphetamine-dextroamphetamine ER (Adderall XR®) member **must** have tried and failed **30 days of therapy with:**
  - ❑ **Brand Adderall XR®**

AND

  - ❑ Provider MUST submit clinical chart notes and a completed MedWatch form documenting the experienced treatment failure/intolerance with brand Adderall XR®

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

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

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.****

Member Name: _____

Member ID #: _____

Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____

Date: _____

Office Contact Name**:**_____

Phone Number: _____

Fax Number: _____

DEA OR NPI #:

_____

***Approved by Pharmacy and Therapeutics Committee**: 7/17/2014; 1/18/2018;
REVISED/UPDATED: 12/12/2016; 8/10/2017; 3/20/2018; 6/25/2018; (Reformatted) 6/3/2019; 7/17/2019; 8/13/2019; **12/7/2020**; **9/10/2021**, **11/8/2021**

SENTARA COMMUNITY PLAN
(MEDICAID)
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 will be delayed.**

STIMULANTS/ADHD MEDICATIONS
Length of Authorization: ONE YEAR)

DRUG INFORMATION: Authorization may be delayed if incomplete.		
Drug Name:	**Dosage Form/Strength:**	**Quantity per Day:**
Dosing Schedule:	**Total Daily Dose:**	**Weight in Kilograms:**
Diagnosis: _____		

❑ **New Therapy** **OR** ❑ **Continuation Therapy**

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(Preferred stimulants/ADHD medications for individuals 4 years to 17 years do not require a Prior Authorization. If request is for a non-preferred non-stimulant, go to Question 9 and submit form.)

Stimulants prescribed for children UNDER the age of four (4) must be prescribed by pediatric psychiatrist, pediatric neurologist, developmental/behavior pediatrician, or in consultation with one of these specialists.

If the child is UNDER 4 YEARS OF AGE and a stimulant is being prescribed:

- **Is the prescriber a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists**?

❑ **YES** ❑ **NO**

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.

Stimulants/ADHD medications for adults over 18 – to receive an approval for this drug, complete the following questions. This does not apply to non-stimulant ADHD medications (such as atomoxetine, Strattera®, clonidine ER, Kapvay®, guanfacine ER, Intuniv®, etc.).

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Does the member meet the following criteria?

1. Indicate the diagnoses being treated (include all ICD codes, if applicable):

   _____

   _____

2. Did 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**
3. Has prescriber reviewed the **Virginia Prescription Monitoring Program (PMP)** on the date of this request?
   https://www.dhp.virginia.gov/PractionerResources/PrescriptionMonitoringProgram/0
   - ❑ **Yes**
   - ❑ **No**
4. Prescriber ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant within 30 days of this request and a copy of the most recent UDS is attached. (**The urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates.)**
   - ❑ **Yes**
   - ❑ **No**

Maintenance Request. Does member meet the following criteria?

5. The practitioner checked the Prescription Monitoring Program at least **every three months** after the initiation of treatment.
   - ❑ **Yes**
   - ❑ **No**

   Please provide the date of the most recent check: _____
6. Has practitioner ordered and reviewed a random urine drug screen **at least every <u>six months?</u>**
   - ❑ **Yes**
   - ❑ **No**

   Please provide the date of the most recent check: _____
7. The practitioner regularly evaluated the member for stimulant and/or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate health care provider, or referred the patient for evaluation for treatment if indicated.
   - ❑ **Yes**
   - ❑ **No**

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To request a non-preferred drug, please answer the questions below, providing all requested information:

8. For non-preferred stimulants/ADHD medications, list pharmaceutical drugs attempted and outcome:

_____

_____

_____

_____

9. Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this member.

_____

_____

_____

_____

TABLE 1: LIST OF PREFERRED AND NON-PREFERRED* DRUGS	
*If requesting a **non-preferred drug,** member must have tried and failed **at least 30 days** of therapy with **two (2) Preferred alternatives**. Please check the box next to the preferred alternatives that were tried and failed.	
PREFERRED	**NON-PREFERRED**
AMPHETAMINE DRUGS	
❑ Adderall® XR ❑ amphetamine salts combo (generic for Adderall® IR) ❑ dextroamphetamine (generic for Dexedrine) ❑ Vyvanse® cap/chewable tab (lisdexamfetamine)	❑ Adderall® IR (amphetamine salts combo) ❑ Adzenys XR ODT™ ❑ Adzenys ER™ susp ❑ Adzenys ER™ ❑ amphetamine salts combo XR ❑ amphetamine sulfate (generic Evekeo™) ❑ Desoxyn® ❑ Dexedrine® ❑ Dyanavel® XR susp ❑ dextroamphetamines SR & soln ❑ Evekeo™ ❑ Evekeo™ ODT ❑ methamphetamine ❑ Mydayis™ ER ❑ Procentra® soln ❑ Zenzedi™

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METHYLPHENIDATE DRUGS	
❑ All methylphenidate IR generic*	❑ Adhansia™ XR
❑ Concerta®	❑ Aptensio™ XR
❑ Daytrana® Transdermal	❑ Cotempla XR-ODT™
❑ Focalin® IR and XR	❑ dexmethylphenidate IR & XR
	❑ Metadate CD®
	❑ Metadate ER®
	❑ Methylin ER®, soln IR
	❑ methylphenidate chew & soln IR
	❑ methylphenidate ER, LA, SR
	❑ methylphenidate ER (generic Relexxii®)
	❑ methylphenidate ER (generic Aptensio™ XR)
	❑ QuilliChew™ ER
	❑ Quillivant™ XR susp
	❑ Ritalin® IR, LA, & SR

MISCELLANEOUS DRUGS	
❑ atomoxetine (generic for Strattera®)	❑ armodafinil (generic Nuvigil™) ***
❑ guanfacine ER	❑ modafinil***
❑ clonidine ER	❑ Nuvigil™ **(AG)***
	❑ Provigil® **(AG)***
	❑ Sunosi®***
	❑ Wakix®***
	❑ Strattera®
	❑ Intuniv®
	❑ Qelbree®
	*** **Refer to Narcolepsy Medications PA Form for these specific drugs**

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.

Member Name: _____

Member ID #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~12/9/2016; 1/20/2017; 1/27/2017; 8/9/2017; 9/29/2017; 5/30/2018; 8/20/2018; 9/29/2018; 3/13/2019; (Reformatted) 3/31/2019; 6/18/2019; 7/2/2019; 12/23/2019; 6/18/2020; 6/29/2021;~~ **1/10/2022**