

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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

STIMULANTS/ADHD MEDICATIONS

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: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

New Therapy OR Continuation Therapy

Preferred stimulants/ADHD medications for individuals 4 years to 17 years do not require a Prior Authorization.

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 or behavioral pediatrician, or in consultation with one of these specialists?

Yes NO

(Continued on next page)

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, guanfacine ER, Intuniv®, Qelbree®, Onyda™ XR etc. See question 4.).**

Does the member meet the following criteria?

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

2. 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

3. For **Vyvanse Chewable** tablets requests only:

- Member has tried and failed methylphenidate solution

4. For **Intuniv®, Strattera®, Onyda™ XR, and Qelbree®**: Member has tried and failed 2 of the preferred agents: atomoxetine, clonidine ER, and/or guanfacine ER.

- Yes
 No

Maintenance Request. Does member meet the following criteria?

5. 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

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

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

7. 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 **two (2) Preferred alternatives of the same class**. Please check the box next to the preferred alternatives that were tried and failed.

PREFERRED	NON-PREFERRED
AMPHETAMINE DRUGS	
<ul style="list-style-type: none"> <input type="checkbox"/> amphetamine salts combo (generic for Adderall® IR) <input type="checkbox"/> amphetamine salts combo XR (generic for Adderall XR) <input type="checkbox"/> dextroamphetamine tab (generic for Dexedrine) <input type="checkbox"/> dextroamphetamine cap SR (generic for Dexedrine Spansule) <input type="checkbox"/> Vyvanse® cap (lisdexamfetamine) 	<ul style="list-style-type: none"> <input type="checkbox"/> Adderall® IR (amphetamine salts combo) <input type="checkbox"/> Adderall® XR (amphetamine salts combo) <input type="checkbox"/> Adzenys XR ODT™ <input type="checkbox"/> Adzenys ER™ susp <input type="checkbox"/> Adzenys ER™ <input type="checkbox"/> amphetamine sulfate (generic Evekeo™) <input type="checkbox"/> amphetamine susp (generic Adzenys ER™ susp) <input type="checkbox"/> amphetamine ER ODT (generic for Adzenys XR ODT™) <input type="checkbox"/> Desoxyn® <input type="checkbox"/> Dexedrine® <input type="checkbox"/> Dyanavel® XR susp <input type="checkbox"/> Dextroamphetamine soln <input type="checkbox"/> Evekeo™ <input type="checkbox"/> lisdexamfetamine (generic Vyvanse®) <input type="checkbox"/> methamphetamine <input type="checkbox"/> Mydayis™ ER <input type="checkbox"/> Procentra® soln <input type="checkbox"/> Vyvanse® chewable tab (Member must have tried and failed methylphenidate solution) <input type="checkbox"/> Xelstrym™ <input type="checkbox"/> Zenzedi™

(Continued on next page)

PREFERRED	NON-PREFERRED
METHYLPHENIDATE DRUGS	
<ul style="list-style-type: none"> <input type="checkbox"/> All methylphenidate IR generic <input type="checkbox"/> Concerta[®] <input type="checkbox"/> Daytrana[®] Transdermal <input type="checkbox"/> dexmethylphenidate XR <input type="checkbox"/> dexmethylphenidate IR <input type="checkbox"/> methylphenidate solution 	<ul style="list-style-type: none"> <input type="checkbox"/> Adhansia[™] XR <input type="checkbox"/> Aptensio[™] XR <input type="checkbox"/> Azstarys[™] <input type="checkbox"/> Cotempla XR-ODT[™] <input type="checkbox"/> Focalin[®] XR <input type="checkbox"/> Focalin[®] IR <input type="checkbox"/> Jornay PM <input type="checkbox"/> Metadate CD[®] <input type="checkbox"/> Metadate ER[®] <input type="checkbox"/> Methylin ER[®], soln IR <input type="checkbox"/> methylphenidate chew <input type="checkbox"/> methylphenidate ER, LA, SR <input type="checkbox"/> methylphenidate ER (generic Relexxii[®]) <input type="checkbox"/> methylphenidate ER (generic Aptensio[™] XR) <input type="checkbox"/> QuilliChew[™] ER <input type="checkbox"/> Quillivant[™] XR susp <input type="checkbox"/> Ritalin[®] IR, LA, & SR
MISCELLANEOUS DRUGS	
<ul style="list-style-type: none"> <input type="checkbox"/> atomoxetine (generic for Strattera[®]) <input type="checkbox"/> guanfacine ER <input type="checkbox"/> clonidine ER 	<ul style="list-style-type: none"> <input type="checkbox"/> Intuniv[®] <input type="checkbox"/> Qelbree[®] <input type="checkbox"/> Strattera[®] <input type="checkbox"/> Onyda[™] XR

*****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.****