# 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**

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**Preferred stimulants/ADHD medications for individuals 4 years to 17 years do not require Prior Authorization. Member must meet the minimum FDA approved age.**

**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, Atoncy™ 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 **atomoxetine sol** (generic Atoncy™), **Atoncy™**, **Intuniv®, 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 prescriber has 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 member 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:

   _____

   _____

   _____

**(Continued on next page)**

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** | |
| ❑ amphetamine salts combo (generic for Adderall® IR)<br>❑ amphetamine salts combo XR (generic for Adderall® XR)<br>❑ dextroamphetamine tab (generic for Dexedrine®)<br>❑ dextroamphetamine cap SR (generic for Dexedrine Spansule)<br>❑ Vyvanse® cap (lisdexamfetamine) | ❑ Adderall® IR (amphetamine salts combo)<br>❑ Adderall® XR (amphetamine salts combo)<br>❑ Adzenys XR ODT™<br>❑ Adzenys ER™ susp<br>❑ Adzenys ER™<br>❑ amphetamine sulfate (generic Evekeo™)<br>❑ amphetamine susp (generic Adzenys ER™ susp)<br>amphetamine ER ODT (generic for Adzenys XR ODT™)<br>❑ Arynta™<br>❑ Desoxyn®<br>❑ Dexedrine®<br>❑ Dyanavel® XR susp<br>❑ Dextroamphetamine soln<br>❑ Evekeo™<br>❑ lisdexamfetamine (generic Vyvanse®)<br>❑ methamphetamine<br>❑ Mydayis™ ER<br>❑ Procentra® soln<br>❑ Vyvanse® chewable tab **(Member must have tried and failed methylphenidate solution)**<br>❑ Xelstrym™<br>❑ Zenzedi™ |

**(Continued on next page)**

| PREFERRED | NON-PREFERRED |
|---|---|
| **METHYLPHENIDATE DRUGS** | |
| ❑ All methylphenidate IR generic<br>❑ methylphenidate ER (generic Concerta®)<br>❑ methylphenidate ER (generic Metadate ER®)<br>❑ Daytrana® Transdermal<br>❑ dexmethylphenidate XR<br>❑ dexmethylphenidate IR<br>❑ methylphenidate solution | ❑ Aptensio™ XR<br>❑ Azstarys™<br>❑ Concerta®<br>❑ Cotempla XR-ODT™<br>❑ Focalin® XR<br>❑ Focalin® IR<br>❑ Jornay PM<br>❑ methylphenidate CD cap (generic Metadate CD)<br>❑ Methylin ER®, soln IR<br>❑ methylphenidate chew<br>❑ methylphenidate, LA, SR<br>❑ methylphenidate ER (generic Relexxii®)<br>❑ methylphenidate ER (generic Aptensio™ XR)<br>❑ methylphenidate (generic Daytrana®)<br>❑ Ritalin® IR, LA®<br>❑ Relexxii®<br>❑ QuilliChew™ ER<br>❑ Quillivant™ XR susp |
| **MISCELLANEOUS DRUGS** | |
| ❑ atomoxetine (generic for Strattera®)<br>❑ clonidine ER<br>❑ guanfacine ER | ❑ atomoxetine sol (generic Atoncy)<br>❑ Atoncy™<br>❑ Intuniv®<br>❑ Qelbree®<br>❑ 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.***



**REVISED/REFORMATTED/UPDATED:** ~~8/20/2018; 9/29/2018; 3/13/2019; 3/31/2019; 6/18/2019; 7/2/2019; 12/23/2019; 6/18/2020; 6/29/2021;1/10/2022, 6/27/2022; 12/27/2022; 3/2/2023;06/28/2023; 11/8/2023; 6/10/2024; 8/21/2024, 12/26/2024; 12/31/2024; 3/24/2025; 8/4/2025; 10/20/2025; 4/27/2026; 6/4/2026; 7/9/2026,~~ **8/6/2026**