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: _____

❑ Request is being submitted for **BRAND** ❑ Request is being submitted for **GENERIC**

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. 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, 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®, OnydaTM 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 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 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.

   _____

   _____

(Continued on next page)

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

(Continued on next page)

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