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

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

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

==========

(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 8 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 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, Kapvay®, guanfacine ER, Intuniv®, Qelbree® etc.).

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**

Maintenance Request. Does member meet the following criteria?

3. 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:

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

   _____

   _____

5. 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	
❑ 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 ❑ Xelstrym™ ❑ Zenzedi™
METHYLPHENIDATE DRUGS	
❑ All methylphenidate IR generic ❑ Concerta® ❑ Daytrana® Transdermal ❑ dexmethylphenidate XR ❑ dexmethylphenidate IR ❑ methylphenidate solution	❑ Adhansia™ XR ❑ Aptensio™ XR ❑ Azstarys™ ❑ Cotempla XR-ODT™ ❑ Focalin® XR ❑ Focalin® IR ❑ Jornay PM ❑ Metadate CD® ❑ Metadate ER® ❑ Methylin ER®, soln IR ❑ methylphenidate chew ❑ methylphenidate ER, LA, SR ❑ methylphenidate ER (generic Relexxii®) ❑ methylphenidate ER (generic Aptensio™ XR) ❑ QuilliChew™ ER ❑ Quillivant™ XR susp ❑ Ritalin® IR, LA, & SR

(Continued on next page)

MISCELLANEOUS DRUGS	
❑ atomoxetine (generic for Strattera®) ❑ guanfacine ER ❑ clonidine ER	❑ armodafinil (generic Nuvigil™) *** ❑ modafinil*** ❑ 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.****