iowa total care. ia health link Hawki

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
CNS STIMULANTS AND ATOMOXETINE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior Authorization (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Prior to requesting PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for CNS stimulants and atomoxetine will be considered when patient has an FDA approved or compendia indication for requested drug under the following conditions: 1) Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, Snap-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. Adults (≥ 21 years of age) are limited to the use of long-acting agents only. If a supplemental dose with a short-acting agent is needed for an adult in the mid to late afternoon, requests will be considered under the following circumstances: the dose of the long-acting agent has been optimized, documentation is provided a short-acting agent of the same chemical entity is medically necessary (e.g. employed during the day with school in the evening), and will be limited to one unit dose per day. Children (< 21 years of age) are limited to the use of long-acting agents with one unit of a short acting agent per day. Use of an amphetamine agent plus a methylphenidate agent will not be considered for a diagnosis of ADHD. 2) Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG). 3) Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.

Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. * If a non-preferred long-acting medication is requested, a trial with the preferred extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Requests for Vyvanse for Binge Eating Disorder must be submitted on the Binge Eating Disorder Agents PA form.

Preferred

- ☐ Amphetamine Salt Combo
- ☐ Amphetamine ER Caps
- ☐ Armodafinil
- ☐ Atomoxetine
- ☐ Concerta
- ☐ Dexmethylphenidate ER Caps
- ☐ Dexmethylphenidate Tabs
- ☐ Dextroamphetamine EE Caps
- ☐ Dextroamphetamine Tabs
- ☐ Dyanavel XR Suspension
- ☐ Methylphenidate CD Caps
- ☐ Methylphenidate IR Tabs
- ☐ Methylphenidate ER Tabs
- ☐ Methylphenidate LA Caps
- ☐ Methylphenidate Solution
- ☐ Modafinil
- ☐ Quillichew ER
- ☐ Sunosi (step through armodafinil or modafinil)

Non-Preferred

- ☐ Adderall
- ☐ Adderall XR
- ☐ Adhansia XR*
- ☐ Adzenys ER Susp
- ☐ Adzenys XR ODT
- ☐ Amphetamine ER Suspension
- ☐ Amphetamine Sulfate Tabs
- ☐ Aptensio XR*
- ☐ Azstarys
- ☐ Cotempla*
- ☐ Daytrana
- ☐ Desoxyn
- ☐ Dexedrine
- ☐ Dyanavel XR Chew Tab
- ☐ Evekeo
- ☐ Focalin
- ☐ Focalin XR
- ☐ Jornay PM
- ☐ Methylin Solution
- ☐ Methylphenidate Chew
- ☐ Methylphenidate TD Patch
- ☐ Methylphenidate ER 72mg Tabs
- ☐ Methylphenidate ER Caps*
- ☐ Methylphenidate XR Caps*
- ☐ Mydayis*
- ☐ Nuvigil
- ☐ Procentra
- ☐ Provigil
- ☐ Quillivant XR
- ☐ Ritalin
- ☐ Ritalin LA*
- ☐ Strattera
- ☐ Vyvanse

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Strength_____ **Dosage Instructions** _____**Quantity** _____ **Days Supply**_____

Diagnosis:

☐ **Attention Deficit Hyperactivity Disorder (ADHD)**

Age of patient at onset of symptoms: _____

Date of most recent clinical visit confirming improvement in symptoms from baseline: _____

Rating scale used to determine diagnosis: _____

Documentation of clinically significant impairment in two or more **current** environments (social, academic, or occupational).

Current Environment 1 & description: _____

Current Environment 2 & description: _____

Requests for short-acting agents:

Has dose of long-acting agent been optimized? ❑ Yes ❑ No

Adults: Provide medical necessity for the addition of a short-acting agent: _____

_____

Children: Provide medical necessity for the need of more than one unit of a short-acting agent: _____

_____

☐ **Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)**

☐ **Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS)**

Have non-pharmacological treatments been tried? ☐ No ☐ Yes *If Yes, please indicate below:*

☐ Weight Loss ☐ Position therapy

☐ CPAP Date: _____ Maximum titration? ☐ Yes ☐ No

☐ BiPAP Date: _____ Maximum titration? ☐ Yes ☐ No

☐ Surgery Date: _____

Specifics:_____

Diagnosis confirmed by a sleep specialist? ❑ Yes ❑ No

☐ **Other (specify)**_____

Prescriber review of patient's controlled substances use on the Iowa PMP website:

☐ No ☐ Yes Date Reviewed:_____

Please document prior psychostimulant trial(s) and failures(s) including drug name(s) strength, dose, exact date ranges and failure reasons:_____

_____

_____

Other - Please provide all pertinent medication trial(s) relating to the diagnosis including drug name(s) strength, dose and exact date ranges: _____

_____

Reason for use of Non-Preferred drug requiring approval:_____

_____

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*