



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 ( $\geq$  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 longacting 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 Non-Preferred Amphetamine Salt Combo Adderall Amphetamine ER Caps Adderall XR Adhansia XR\* Armodafinil Atomoxetine Adzenys ER Susp Concerta Adzenys XR ODT Dexmethylphenidate ER Caps Amphetamine ER Suspension Dexmethylphenidate Tabs Amphetamine Sulfate Tabs Dextroamphetamine EE Caps Aptensio XR\* Dextroamphetamine Tabs Azstarys Dyanavel XR Suspension Cotempla\* Methylphenidate CD Caps Daytrana Methylphenidate IR Tabs Desoxyn Methylphenidate ER Tabs Dexedrine Methylphenidate LA Caps Dyanavel XR Chew Tab Methylphenidate Solution Evekeo Modafinil Focalin **Ouillichew ER** Focalin XR **Quillivant XR Jornay PM** Sunosi (step through armodafinil or modafinil) Lisdexamfetamine

Methylin Solution Methylphenidate Chew Methylphenidate TD Patch Methylphenidate ER 45,63,72mg Tabs Methylphenidate ER Caps\* Methylphenidate XR Caps\* Mydayis\* Nuvigil Procentra Provigil Relexxii Ritalin **Ritalin LA\*** Strattera Vyvanse ☐ Xelstrym

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## **CNS STIMULANTS AND ATOMOXETINE**

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Strength	Dosage Instructions	Quantity	Days Supply
Diagnosis:			
Attenti	on Deficit Hyperactivity Disorder (ADH	ID)	
Did patient h	nave inattentive or hyperactive/impulsive symp	otoms present prior to age	12? 🗌 Yes 🔲 No
Date of most	t recent clinical visit confirming improvement	in symptoms from baseline	:
Rating scale u	used to determine diagnosis:		
Documentati	ion of clinically significant impairment in two o	or more <b>current</b> environm	ents (social, academic, or occupational).
Current Envi	ironment   & description:		
Current Envi	ironment 2 & description:		
Requests fo	or short-acting agents:		
Has dose of I	long-acting agent been optimized? 🔲 Yes	🗌 No	
Adults: Provi	de medical necessity for the addition of a sho	ort-acting agent:	
Children: Pro	ovide medical necessity for the need of more	than one unit of a short-act	ing agent:
C Bi Su Specif Diagnos	/eight Loss	Maximum titration?	☐ Yes ☐ No ☐ Yes ☐ No
	view of patient's controlled substances u	ise on the Iowa PMP we	bsite:
🗌 No 🔲 Yes	Date Reviewed:		
	t prior psychostimulant trial(s) and failures(s)		ength, dose, exact date ranges and failure
	provide all pertinent medication trial(s) relat		g drug name(s) strength, dose and exact date
Reason for use o	of Non-Preferred drug requiring approval:		· · · · · · · · · · · · · · · · · · ·
Prescriber sign	nature (Must match prescriber listed above.)		Date of submission
IMPORTANT NO	<b>OTE:</b> In evaluating requests for prior authorization th	e consultant will consider the tree	atment from the standboint of medical necessity only

**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 Health and Human Services, that the member continues to be eligible for Medicaid.