Iowa Department of Human Services

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

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 at https://pmp.iowa.gov/IAPMPWebCenter/. Payment for CNS stimulants and atomoxetine will be considered under the following conditions: 1) Attention Deficit Disorder (ADD) or 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 the patient continues to require medication to treat the symptoms of ADD/ADHD will be required for renewals or patients newly eligible that are established on medication to treat ADD/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 immediate release and 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

- ☐ Adzenys XR ODT
- ☐ Amphetamine Salt Combo
- ☐ Amphetamine ER Caps
- ☐ Atomoxetine
- ☐ Daytrana
- ☐ Dexmethylphenidate Tabs
- ☐ Dexmethylphenidate ER Caps
- ☐ Methylin Solution
- ☐ Methylphenidate CD Caps
- ☐ Methylphenidate IR Tabs
- ☐ Methylphenidate ER Tabs (18, 27, 36, 54mg)
- ☐ Methylphenidate LA Caps
- ☐ Modafinil
- ☐ Quillichew ER
- ☐ Vyvanse

Non-Preferred

- ☐ Adderall
- ☐ Adderall XR*
- ☐ Aptensio XR*
- ☐ Armodafinil
- ☐ Concerta
- ☐ Desoxyn
- ☐ Dexedrine*
- ☐ Dextroamphetamine ER Cap*
- ☐ Dyanavel XR
- ☐ Evekeo
- ☐ Focalin
- ☐ Focalin XR
- ☐ Metadate CD
- ☐ Methylin Chew
- ☐ Methylphenidate ER Tabs (10mg & 20mg)*
- ☐ Nuvigil
- ☐ Procentra
- ☐ Provigil
- ☐ Quillivant XR
- ☐ Ritalin
- ☐ Ritalin LA*
- ☐ Strattera

Strength____________ **Dosage Instructions** ____________________**Quantity** _______**Days Supply**___________

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Diagnosis:

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

Age of patient at onset of symptoms: ________________________

Date of most recent clinical visit confirming initial or continued diagnosis: __________________

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: ____

☐ **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:____

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

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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.*