



Request for Prior Authorization
CNS STIMULANTS AND ATOMOXETINE

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, 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

- Amphetamine Salt Combo
Amphetamine ER Caps
Aptensio XR
Armodafinil
Atomoxetine
Daytrana
Dexmethylphenidate Tabs
Focalin XR
Methylin Solution
Methylphenidate IR Tabs
Methylphenidate ER Tabs (18, 27, 36, 54mg)

- Methylphenidate LA Caps
Modafinil
Quillichew ER
Quillivant XR
Vyvanse

Non-Preferred

- Adderall
Adderall XR*
Adzenys XR ODT
Concerta
Cotempla*
Desoxyn
Dexedrine*
Dexmethylphenidate ER Caps
Dextroamphetamine ER Cap*
Dyanavel XR
Evekeo
Focalin
Methylphenidate CD Caps
Methylin Chew
Methylphenidate ER Tabs (10mg & 20mg)*
Mydayis*
Nuvigil
Procentra
Provigil
Ritalin
Ritalin LA
Strattera

Strength Dosage Instructions Quantity Days Supply

**Request for Prior Authorization
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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: _____

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
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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.