Iowa Department of Human Services

Request for Prior Authorization
CNS STIMULANTS AND ATOMOXETINE

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(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

- ☐ Amphetamine Salt Combo
- ☐ Amphetamine ER Caps
- ☐ Aptensio XR
- ☐ Armodafinil
- ☐ Atomoxetine
- ☐ Concerta
- ☐ Daytrana
- ☐ Dexmethylphenidate Tabs
- ☐ Focalin XR
- ☐ Methylin Solution
- ☐ Methylphenidate CD Caps
- ☐ Methylphenidate IR Tabs
- ☐ Methylphenidate ER 20mg Tabs
- ☐ Methylphenidate LA Caps
- ☐ Modafinil
- ☐ Quillichew ER
- ☐ Quillivant XR
- ☐ Vyvanse

Non-Preferred

- ☐ Adderall
- ☐ Adderall XR*
- ☐ Adzenys XR ODT
- ☐ Cotempla*
- ☐ Desoxyn
- ☐ Dexedrine*
- ☐ Dexmethylphenidate ER Caps
- ☐ Dextroamphetamine ER Caps*
- ☐ Dyanavel XR
- ☐ Evekeo
- ☐ Focalin
- ☐ Methylin Chew
- ☐ Methylphenidate ER Tabs
- ☐ Mydayis*
- ☐ Nuvigil
- ☐ Procentra
- ☐ Provigil
- ☐ Ritalin
- ☐ Ritalin LA
- ☐ Straterra

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

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

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.*