CNS Stimulants and Atomoxetine
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004.
Provider Help Desk: 800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Requests will be considered for an FDA approved age for the submitted diagnosis. 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. Payment for CNS stimulants and atomoxetine will be considered 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 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 (for example, 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.
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 nonpreferred 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
☐ Dexmethylphenidate ER Caps
☐ Dexmethylphenidate Tabs
☐ Dextroamphetamine EE Caps
☐ Dextroamphetamine Tabs
☐ Methyphenidate CD Caps
☐ Methylphenidate IR Tabs
☐ Methylphenidate ER Tabs
☐ Methylphenidate Solution
☐ Modafanil
☐ Quillichew ER
☐ Quillivant XR
☐ Vyvanese

Non-preferred

☐ Adderall
☐ Adderall XR
☐ Adhansia XR*
☐ Adzenys ER Susp
☐ Adzenys XR ODT
☐ Amphetamine Sulfate Tabs
☐ Aptensio XR*
☐ Cotempla*
☐ Daytrana
☐ Desoxyn
☐ Dexedrine
☐ Dyanavel XR
☐ Evekeo
☐ Focalin
☐ Focalin XR
☐ Jornay PM
☐ Methylin Solution
☐ Methylphenidate Chew
☐ Methylphenidate ER 72mg Tabs
☐ Methylphenidate ER Caps*
☐ Methylphenidate LA Caps*
☐ Mydayis*
☐ Nuvigil
☐ Procentra
☐ Provigil
☐ Ritalin
☐ Ritalin LA*
☐ Straterra

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 and description: _____
Current environment 2 and description: _____

Requests for short-acting agents for adults:
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 nonpharmacological treatments been tried? ☐ Yes ☐ No *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:
☐ Yes ☐ No 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 nonpreferred drug requiring approval: _____
_____

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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.*