

Request for Prior Authorization: CNS Stimulants

Iowa | Iowa Health Link • Hawki

Contains confidential patient information

Instructions

Complete this form in its entirety and fax it to the Prior Authorization of Benefits Center at **844-512-9004**. If you have any questions, use the Chat with Payer feature in <https://Availity.com> or contact Provider Services at **833-731-2143**, Monday through Friday, 7:30 a.m. to 6 p.m. CT.

1. Patient information

2. Provider and pharmacy information

IA Medicaid member ID:	Prescriber NPI:
Patient name:	Prescriber name:
DOB:	Prescriber phone:
Patient address:	Prescriber address:
	Prescriber fax:
	Pharmacy name:
	Pharmacy address:
	Pharmacy phone:
Prescriber must complete all information above. It must be legible, correct, and complete or the form will be returned.	
Pharmacy NPI:	Pharmacy fax:
NDC:	

3. Approval criteria

Select all boxes that apply. Note: Any areas not filled out will be considered not applicable to your patient and may affect the outcome of this request.

Prior authorization (PA) is required for CNS stimulants 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 the requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for CNS stimulants will be considered when the patient has an FDA-approved or compendia indication for the 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 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 who 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 that a short-acting agent of the same chemical entity is medically necessary (for example, employed during the day with school in the evening), and the agent 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. 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 nonpharmacological 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.

Medications marked with *: If a nonpreferred 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.

4. Drug selection

Preferred

- Amphetamine Salt Combo
- Amphetamine ER Caps
- Armodafinil
- Concerta
- Dexmethylphenidate ER Caps
- Dexmethylphenidate Tabs
- Dextroamphetamine ER Caps
- Dextroamphetamine Tabs (5mg and 10mg)
- Dyanavel XR Suspension
- Focalin XR
- Jornay PM
- Methylphenidate CD Caps
- Methylphenidate IR Tabs
- Methylphenidate ER Tabs
- Methylphenidate LA Caps
- Methylphenidate Solution
- Modafinil
- Procentra
- Quillichew ER
- Quillivant XR
- Sunosi (step through armodafinil or modafinil)

Nonpreferred

- Adderall
- Adderall XR
- Adzenys XR ODT
- Amphetamine Sulfate Tabs
- Amphetamine/Dextroamphetamine 3 Bead Cap ER
- Amphetamine ER ODT
- Aptensio XR*
- Azstarys
- Cotempla*
- Daytrana
- Dexedrine
- Dextroamphetamine Tabs
- Dyanavel XR Chew Tab
- Evekeo
- Focalin
- Lisdexamphetamine
- Methylin Solution
- Methylphenidate Chew
- Methylphenidate TD Patch
- Methylphenidate ER 45, 63, 72mg Tabs
- Methylphenidate ER Caps*
- Methylphenidate XR Caps*
- Mydayis*
- Nuvigil
- Provigil
- Relexxii*
- Ritalin
- Ritalin LA*
- Vyvanse
- Wakix
- Xelstrym

Strength	Dosage instructions	Quantity	Days supply

5. Diagnosis

Attention Deficit Hyperactivity Disorder (ADHD)

Did the patient have inattentive or hyperactive/impulsive symptoms present prior to age 12?

Yes No

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 — description:

Current environment 2 — description:

Requests for short-acting agents

Has the dose of the 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 for 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, 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 the patient’s controlled substances use on the Iowa PMP website.

Yes No Date reviewed: _____

Please document prior psychostimulant trial(s) and failure(s) relating to the diagnosis, including drug name(s), strength, dose, and exact date ranges.

Psychostimulant drug trial 1			
Name and dose		Trial dates	
Failure reason			

Psychostimulant drug trial 2			
Name and dose		Trial dates	
Failure reason			

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

Drug trial 1			
Name and dose		Trial dates	
Failure reason			

Drug trial 2			
Name and dose		Trial dates	
Failure reason			

Reason for use of nonpreferred drug requiring approval:

Attach lab results and other documentation as necessary.

6. Physician signature

Prescriber or authorized signature
(Must match prescriber named above.)

Date submitted

Prior authorization of benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Refer to the applicable plan for detailed information regarding benefits, conditions, limitations, and exclusions. The submitting care 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.

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 care 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.