OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; fax to **1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete forms will delay the authorization process.**

Drug Requested: **Stimulants/ADHD Medications**

Length of Authorization: **ONE YEAR**

DRUG INFORMATION: Complete the information below to qualify or authorization process will be delayed.		
Drug Name:	**Dosage Form/Strength**:	**Quantity:**
Administration Schedule:	**Total Daily Dose:**	❒ New Therapy **OR** ❒ Continuation Therapy

Clinical Criteria: The following criteria **MUST** be met or authorization process will be delayed.

1. Is the patient between the ages 0-3?	❒ Yes – if yes, complete section A. ❒ No
2. Is the patient between the ages 4-17?	❒ Yes – if yes, complete section B. ❒ No
3. Is the patient 18 years of age or older?	❒ Yes – if yes, complete section C. ❒ No

Section A: Patient between the ages 0-3

1. Are you a **pediatric psychiatrist**, **pediatric neurologist**, or **developmental/behavioral pediatrician**?
   - ❒ Yes – indicate specialty: _____then skip to question 3
   - ❒ No – if no, complete question 2
2. Has the prescriber consulted with a Psychiatrist, Neurologist, or Developmental/Behavioral Pediatrician prior to prescribing the requested medication?
   - ❒ Yes – if yes, complete: Name: _____ Specialty: _____ Date of Consult: _____
   - ❒ No
3. Are you prescribing a preferred drug? **Refer to Table 1 for list of preferred/non-preferred drugs.**
   - ❒ Yes – if YES, check the box in the table next to the preferred drug you are requesting
   - ❒ No – if NO, check the boxes in the table next to the preferred alternatives that the patient has tried and failed, then check the box next to the non-preferred drug you are requesting
4. Submit completed form.

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Section B: Patient between the ages 4-17

1. Are you prescribing a preferred drug? **Refer to Table 1 for list of preferred/non-preferred drugs.**
   - ❒ Yes – if yes, you do not need to submit a prior authorization
   - ❒ No – if no, check the boxes in the table next to the preferred alternatives that the patient has tried and failed, then check the box next to the non-preferred drug you are requesting
2. Submit completed form.

Section C: Patients that are 18 years of age or older

1. Is the patient a new start to Stimulant/ADHD medication?
   - ❒ Yes – if yes, skip to Part 1: Initial Request
   - ❒ No – if no, skip to Part 2: Maintenance Request

Part 1: Initial Request

1. Indicate the diagnoses being treated **(include all ICD 10 codes if applicable*):***

   _____

2. Did the prescriber use the ***Diagnostic and Statistical Manual of Mental Disorders, 5TH Edition*** and determine that criteria have been met (**including documentation of impairment in more than 1 major setting**) to make the diagnosis of ADHD?
   - ❑ Yes
   - ❑ No
3. Has the prescriber reviewed the Virginia Prescription Monitoring Program (PMP) on the date of this request? Use the link to visit the website: https://www.pmp.dhp.virginia.gov/VAPMPWebCenter/login.aspx
   - ❑ Yes – go to question 4
   - ❑ No – go to question 5
4. Document fill date of last opioid Rx, or indicate N/A if there is no opioid Rx:

   _____

   Document fill date of last benzodiazepine Rx, or indicate N/A if there is no benzodiazepine Rx:

   _____
5. Has the prescriber ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant within 30 days of this request. (The urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates).
   - ❑ Yes – if yes, please attach most recent UDS
   - ❑ No
6. Are you prescribing a preferred drug? **Refer to Table 1 for list of preferred/non-preferred drugs.**
   - ❒ Yes – if yes, check the box in the table next to the preferred drug you are requesting
   - ❒ No – if no, check the boxes in the table next to the preferred alternatives that the patient has tried and failed, then check the box next to the non-preferred drug you are requesting
7. Submit completed form.

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Part 2: Maintenance Request

1. Has the practitioner checked the Prescription Monitoring Program at least every three months after the initiation of treatment?
   - ❒ Yes – if yes, provide the date of the most recent check: _____
   - ❒ No
2. Has the practitioner ordered and reviewed a random urine drug screen at least every six (6) months.
   - ❒ Yes – if yes, provide the date of the most recent check: _____
   - ❒ No
3. Has the practitioner regularly evaluated the patient for stimulant and/or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate health care provider, or referred the patient for evaluation for treatment if indicated. ❒ Yes ❒ No
4. Are you prescribing a preferred drug? **Refer to Table 1 for list of preferred/non-preferred drugs.**
   - ❒ Yes – if yes, check the box in the table next to the preferred drug you are requesting
   - ❒ No – if no, check the boxes in the table next to the preferred alternatives that the patient has tried and failed, then check the box next to the non-preferred drug you are requesting
5. Submit completed form.

TABLE 1: LIST OF PREFERRED AND NON-PREFERRED* DRUGS

*If requesting a **non-preferred drug,** patient **MUST** have tried and failed at least 30 days of therapy with two (2) preferred alternatives. **Please check the box next to the preferred alternatives that were tried and failed.**

PREFERRED:	NON-PREFERRED:
AMPHETAMINE DRUGS	
❑ Adderall XR	❑ Adderall IR (amphetamine salts combo)
❑ Amphetamine salt combo (generic for Adderall IR)	❑ Adzenys XR ODT
❑ Dextroamphetamine (generic for Dexedrine)	❑ Adzenys ER susp
❑ Vyvanse cap/chewable tab (lisdexamfetamine)	❑ amphetamine salts combo XR
	❑ Desoxyn
	❑ Dexedrine
	❑ dextroamphetamines SR & soln
	❑ Dyanavel XR susp
	❑ Evekeo
	❑ methamphetamine
	❑ Mydayis ER
	❑ Procentra soln
	❑ Zenzedi

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METHYLPHENIDATE DRUGS	
❑ All methylphenidate IR generic*	❑ Aptensio XR
❑ Concerta	❑ Cotempla XR ODT
❑ Daytrana Transdermal	❑ dexmethylphenidate IR & XR
❑ Focalin IR and XR	❑ Metadate CD
❑ QuilliChew ER	❑ Metadate ER
❑ Quillivant XR susp	❑ Methylin ER, soln IR
	❑ methylphenidate chew & soln
	❑ methylphenidate ER, LA, SR
	❑ Ritalin IR, LA, & SR
MISCELLANEOUS DRUGS	
❑ atomoxetine (generic for Strattera)	❑ armodafinil (generic Nuvigil)
❑ guanfacine ER	❑ clonidine ER (generic Kapvay)
❑ Kapvay SR12 H	❑ modafinil
	❑ Nuvigil (AG)
	❑ Provigil (AG)
	❑ Strattera
	❑ Intuniv

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 11/27/2016
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