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. If information provided is not complete, correct, or legible, authorization will be delayed. One form per member.

STIMULANTS/ADHD MEDICATIONS
(Length of Authorization: ONE YEAR)

<table>
<thead>
<tr>
<th>DRUG INFORMATION: Authorization may be delayed if incomplete.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Name:</td>
</tr>
<tr>
<td>Dosing Schedule:</td>
</tr>
<tr>
<td>Diagnosis:</td>
</tr>
</tbody>
</table>

☐ New Therapy ☄ Continuation Therapy

(Preferred stimulants/ADHD medications for individuals 4 years to 17 years do not require a Prior Authorization. If request is for a non-preferred non-stimulant, go to Question 9 and submit form.)

Stimulants prescribed for children UNDER the age of four (4) must be prescribed by pediatric psychiatrist, pediatric neurologist, developmental/behavior pediatrician, or in consultation with one of these specialists.

If the child is UNDER 4 YEARS OF AGE and a stimulant is being prescribed:

- Is the prescriber a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists?
  ☐ YES ☐ NO

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Stimulants/ADHD medications for adults over 18 – to receive an approval for this drug, complete the following questions. This does not apply to non-stimulant ADHD medications (such as atomoxetine, Strattera®, clonidine ER, Kapvay®, guanfacine ER, Intuniv®, etc.).

(Continued on next page)
Does the member meet the following criteria?

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

_______________________________________________________________________________________________________
_______________________________________________________________________________________________________

2. Did 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 one major setting) to make the diagnosis of ADHD?

☐ Yes
☐ No

3. Has prescriber reviewed the **Virginia Prescription Monitoring Program (PMP)** on the date of this request? [https://www.dhp.virignia.gov/PractionerResources/PrescriptionMonitoringProgram/](https://www.dhp.virignia.gov/PractionerResources/PrescriptionMonitoringProgram/)

☐ Yes
☐ No

4. Prescriber ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant within 30 days of this request and a copy of the most recent UDS is attached. *(The urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates.)*

☐ Yes
☐ No

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**Maintenance Request. Does member meet the following criteria?**

5. The practitioner checked the Prescription Monitoring Program at least **every three months** after the initiation of treatment.

☐ Yes
☐ No

Please provide the date of the most recent check: __________________________

6. Has practitioner ordered and reviewed a random urine drug screen **at least every six months**?

☐ Yes
☐ No

Please provide the date of the most recent check: __________________________

7. The practitioner regularly evaluated the member 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

(Continued on next page)
To request a non-preferred drug, please answer the questions below, providing all requested information:

8. For non-preferred stimulants/ADHD medications, list pharmaceutical drugs attempted and outcome:

______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

9. Provide other pertinent information to support the use of the requested stimulant/ADHD medication for this member.

______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

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

*If requesting a non-preferred drug, member 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.

<table>
<thead>
<tr>
<th>PREFERRED</th>
<th>NON-PREFERRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPHETAMINE DRUGS</td>
<td>AMPHETAMINE DRUGS</td>
</tr>
</tbody>
</table>

- Adderall® XR
- amphetamine salts combo (generic for Adderall® IR)
- dextroamphetamine (generic for Dexedrine)
- Vyvanse® cap/chewable tab (lisdexamfetamine)
- Dyanavel® XR susp

- Adderall® IR (amphetamine salts combo)
- Adzenys XR ODT™
- Adzenys ER™ susp
- Adzenys ER™
- amphetamine salts combo XR
- amphetamine sulfate (generic Evekeo™)
- Desoxyn®
- Dexedrine®
- dextroamphetamines SR & soln
- Evekeo™
- Evekeo™ ODT
- methamphetamine
- Mydayis ER™
- Procentra® soln
- Zenzedi™

(Continued on next page; signature page is required to process request.)
(Please ensure signature page is attached to form.)

<table>
<thead>
<tr>
<th>METHYLPHENIDATE DRUGS</th>
<th>MISCELLANEOUS DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>All methylphenidate IR generic*</td>
<td>adhansia™ XR</td>
</tr>
<tr>
<td>Concerta®</td>
<td>aptensio™ XR</td>
</tr>
<tr>
<td>Daytrana® Transdermal</td>
<td>cotempra XR-ODT™</td>
</tr>
<tr>
<td>Focalin® IR and XR</td>
<td>dexamethylphenidate IR &amp; XR</td>
</tr>
<tr>
<td>Quillichew ER™</td>
<td>metadate CD®</td>
</tr>
<tr>
<td>Quillivant™ X R susp</td>
<td>metadate ER®</td>
</tr>
<tr>
<td></td>
<td>methylphenidate chew &amp; soln IR</td>
</tr>
<tr>
<td></td>
<td>methylphenidate ER, LA, SR</td>
</tr>
<tr>
<td></td>
<td>ritalin® IR, LA®, &amp; SR®</td>
</tr>
<tr>
<td>atomoxetine (generic for strattera®)</td>
<td>armodafinil (generic Nuvigil™)***</td>
</tr>
<tr>
<td>guanfacine ER</td>
<td>modafinil***</td>
</tr>
<tr>
<td>clonidine ER</td>
<td>Nuvigil™ (AG)***</td>
</tr>
<tr>
<td></td>
<td>provigil® (AG)***</td>
</tr>
<tr>
<td></td>
<td>sunosi®***</td>
</tr>
<tr>
<td></td>
<td>strattera®</td>
</tr>
<tr>
<td></td>
<td>intuniv®</td>
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<tr>
<td>*** Refer to Narcolepsy Medications PA Form for these specific drugs</td>
<td></td>
</tr>
</tbody>
</table>

*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.*

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Member Name:  ________________________________________________________________
Member Optima #:  ____________________________________________ Date of Birth:  _________________________
Prescriber Name:  ________________________________________________________________
Prescriber Signature:  _________________________________________ Date:  _____________________
Office Contact Name:  ________________________________________________________________
Phone Number:  ____________________________________________ Fax Number:  ______________________________
DEA OR NPI #:  ________________________________________________________________