

OPTIMA HEALTH PLAN

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 form will delay authorization process.

Non-Preferred Central Nervous System (CNS) Stimulants

DRUG REQUESTED: Check applicable drug below. Box **must** be checked to qualify or authorization process will be delayed.

<input type="checkbox"/> Adzenys XR-ODT™/ Adzenys ER™ Susp	<input type="checkbox"/> Aptensio XR®	<input type="checkbox"/> Cotempla XR-ODT™	<input type="checkbox"/> Daytrana®
<input type="checkbox"/> Dyanavel® XR	<input type="checkbox"/> Mydayis®	<input type="checkbox"/> Quillichew® ER	<input type="checkbox"/> Quillivant XR®

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Name/Form: _____ Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

CLINICAL CRITERIA: Criteria below **MUST** be met and documented to qualify. To ensure the authorization process is **NOT** delayed, all boxes must be checked.

The patient must have tried and failed **30 days of therapy** with:

- Two (2) of the following:**
 - amphetamine-dextroamphetamine IR/ER (generic Adderall/Adderall XR)
 - dexamethylphenidate IR/ER (generic Focalin/Focalin XR)
 - dextroamphetamine IR/SR (generic Dextrostat/Procentra/Zenzedi/Dexedrine)
 - methylphenidate IR/ER (generic Ritalin/Ritalin SR/Ritalin LA/Concerta/Metadate CD)

AND

- Vyvanse®

AND

- If the member is over the age of 18, the member **must** also meet diagnostic criteria. The prior authorization form “CNS Stimulants- Age 19 and Older” can be downloaded from:**
<http://providers.optimahealth.com>

****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: 2/15/2018;
REVISED/UPDATED: 2/19/2018 6/25/2018