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.***

❑ **Adzenys XR-ODT™**	❑ **Aptensio XR®**	❑ **Cotempla XR-ODT™**	❑ **Daytrana®**
❑ **Dyanavel® XR**	❑ **Mydayis®**	❑ **Quillichew® ER**	❑ **Quillivant XR®**

DRUG INFORMATION: ***Complete information below. If incomplete, 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. If boxes are not checked or information is incomplete, authorization process will be delayed.***

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)
  - ❑ dexmethylphenidate 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