

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

CNS Stimulants for Adults Age 19 and Above

- A review of written documentation to substantiate a complete, appropriate, and covered diagnosis for both new starts and members currently receiving any CNS stimulant listed below will be required before Prior Authorization approval. Prescribing history alone WILL NOT meet criteria for approval.

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

Drug Name/Form: _____ Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

DRUG(S) REQUESTED: Check applicable drug(s) below. Box(es) must be checked to qualify or authorization process will be delayed.

<input type="checkbox"/> amphetamine/dextroamphetamine (Adderall)	<input type="checkbox"/> dextroamphetamine ER (Dexedrine Spansule)	<input type="checkbox"/> dexmethylphenidate (Focalin)	<input type="checkbox"/> methylphenidate ER (Ritalin SR/Metadate ER)
<input type="checkbox"/> amphetamine/dextroamphetamine ER (Adderall XR)	<input type="checkbox"/> dextroamphetamine (Dextrostat)	<input type="checkbox"/> dexmethylphenidate ER (Focalin XR)	<input type="checkbox"/> methylphenidate LA (Ritalin LA)
<input type="checkbox"/> Adzenys XR-ODT™ / Adzenys ER™ Susp	<input type="checkbox"/> methamphetamine (Desoxyn)	<input type="checkbox"/> methylphenidate (Ritalin/Methylin)	<input type="checkbox"/> Aptensio XR®
<input type="checkbox"/> Dyanavel® XR	<input type="checkbox"/> Evekeo®	<input type="checkbox"/> methylphenidate ER (Concerta)	<input type="checkbox"/> Quillichew® ER
<input type="checkbox"/> dextroamphetamine (ProCentra)	<input type="checkbox"/> Vyvanse®	<input type="checkbox"/> Daytrana®	<input type="checkbox"/> Quillivant XR®
<input type="checkbox"/> dextroamphetamine (Zenzedi)	<input type="checkbox"/> methylphenidate CD (Metadate CD)	<input type="checkbox"/> Cotempla XR ODT™	<input type="checkbox"/> Mydayis®

DIAGNOSES: Check applicable diagnosis below with ICD Code and description. For ****BINGE EATING DISORDER**, obtain BED specific form, found under “Vyvanse (Binge Eating Disorder).”

ADHD/ADD: ICD-9/10: _____ Description: _____
**please complete table below and attach/fax any documentation as requested*

Narcolepsy: ICD-9/10: _____ Description: _____
**please attach and fax documentation (polysomnogram and MSLT results) to support diagnosis*

Other*: ICD-9/10: _____ Description: _____
**please attach and fax documentation (i.e. chart notes, previous therapies tried) to support diagnosis*

***NON-FDA approved indications** - submit two (2) peer reviewed clinical studies documenting the safety and efficacy of the specified drug for that particular indication.

CLINICAL CRITERIA: Complete ALL information below for an indication of ADHD/ADD. To qualify, boxes MUST be checked. If information is incomplete, authorization process will be delayed.

Name of Diagnosing Prescriber: _____ Date of Diagnosis: _____

If the patient was diagnosed by another prescriber as either a child or an adult, please submit the name of the prescriber, the date of diagnosis, and copies of testing and chart notes detailing signs and symptoms. Include any additional evaluation done as the prescribing physician in the table below or as a faxed attachment.

<input type="checkbox"/> Existence of <u>at least 5</u> symptoms for <u>a minimum of 6 months</u> ? (indicate symptoms below)
<input type="checkbox"/> Inattentive Symptoms: 5 or more
<input type="checkbox"/> Hyperactive-Impulsive Symptoms: 5 or more
<input type="checkbox"/> Combined Symptoms: 10 or more ADHD symptoms including 5 or more inattentive symptoms <u>AND</u> 5 or more hyperactive-impulsive symptoms

(continued on next page)

<input type="checkbox"/> Documentation that symptoms impair or compromise normal functioning.
<input type="checkbox"/> Documentation that symptoms are present in two (2) or more settings/environments (<i>indicate settings</i>): 1. _____ 2. _____
<input type="checkbox"/> Documentation of inattentive or hyperactive-impulsive symptoms before the age of 12 . (<i>if available</i> , indicate source below) <input type="checkbox"/> Medical Chart/Progress Notes documenting childhood diagnosis and/or symptoms <input type="checkbox"/> School Records <input type="checkbox"/> Corroborated by a relative/friend <input type="checkbox"/> Not Available
<input type="checkbox"/> Symptoms are not better explained by another disorder (e.g. Schizophrenia, Mood Disorder, Anxiety Disorder, Substance Abuse, Dissociative Disorder, or Personality Disorder)
<input type="checkbox"/> The diagnosis has been verified using a standardized rating scale, patient interview, or psychological evaluation <input type="checkbox"/> Adult Self-Report Scale- V1.1 <input type="checkbox"/> Patient Interview <input type="checkbox"/> Wender Adult ADHD Rating Scale <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> Other: _____
<input type="checkbox"/> THE PATIENT-SPECIFIC DSM SYMPTOMS, CRITERIA, PSYCHOLOGICAL EVALUATION, AND/OR STANDARDIZED RATING SCALE USED TO MAKE OR VERIFY THE DIAGNOSIS <u>MUST</u> BE SUBMITTED WITH THIS FORM FOR APPROVAL.

If requesting **Adzenys, Aptensio XR, Cotempla XR ODT, Daytrana, Dyanavel XR, Evekeo, Mydayis, Quillichew ER, or Quillivant XR:**

▪ Patient **must** have tried and failed **30 days of therapy with:**

Two (2) of the following:

<input type="checkbox"/> amphetamine-dextroamphetamine IR/ER (generic Adderall/Adderall XR)	<input type="checkbox"/> dexamethylphenidate IR/ER (generic Focalin/Focalin XR)
<input type="checkbox"/> dextroamphetamine IR/SR (generic Dextrostat/Procentra/Zenzedi/Dexedrine)	<input type="checkbox"/> methylphenidate IR/ER (generic Ritalin/Ritalin SR/Ritalin LA/Concerta/Metadate CD)

AND

Vyvanse® (**NOT** required for Evekeo)

****Please be aware if this request is for a dose that exceeds Optima Health's Maximum Daily Dosage Limits, a second prior authorization request will need to be submitted for dosage approval. The correct form 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: 7/17/2014; 1/18/2018;

REVISED/UPDATED: 12/12/2016; 8/10/2017; 3/20/2018; 6/25/2018.