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.***

Drug Requested: 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 information below. If incomplete, 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.**

❑amphetamine/ dextroamphetamine (Adderall)	❑ dextroamphetamine ER (Dexedrine Spansule)	❑ dexmethylphenidate (Focalin)	❑ methylphenidate ER (Ritalin SR/Metadate ER)
❑ amphet/dextroamphetamine ER (Adderall XR)	❑ dextroamphetamine (Dextrostat)	❑ dexmethylphenidate ER (Focalin XR)	❑ methylphenidate LA (Ritalin LA)
❑ Adzenys XR-ODT™	❑ methamphetamine (Desoxyn)	❑ methylphenidate (Ritalin/Methylin)	❑ Aptensio XR™
❑ Dyanavel™ XR	❑ Evekeo®	❑ methylphenidate ER (Concerta)	❑ Quillichew® ER
❑ dextroamphetamine (ProCentra)	❑ Vyvanse®	❑Daytrana®	❑ Quillivant XR®
❑ dextroamphetamine (Zenzedi)	❑ methylphenidate CD (Metadate CD)		

***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 (i.e. polysomnography and MSLT) 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 or incomplete information will delay authorization process.**

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.

(continued on next page)

CLINICAL CRITERIA** (continued): **Check ALL boxes below. Criteria MUST be met and documented or authorization process will be delayed.

- ❑ Existence of ***at least 5*** symptoms for ***a minimum of 6 months*****? *(indicate symptoms below)***
  - ❑ ***Inattentive Symptoms***: 5 or more
  - ❑ ***Hyperactive-Impulsive Symptoms***: 5 or more
  - ❑ ***Combined Symptoms***: 10 or more ADHD symptoms including 5 or more inattentive symptoms **AND** 5 or more hyperactive-impulsive symptoms
- ❑ Documentation that symptoms impair or compromise normal functioning.
- ❑ Documentation that symptoms are present in ***two (2) or more*** settings/environments *(**indicate settings**):*
  1. _____ **2.** _____
- ❑ Documentation of inattentive or hyperactive-impulsive symptoms ***before the age of 12***. (***if available***, indicate source below)
  - ❑ Medical Chart/Progress Notes documenting childhood diagnosis and/or symptoms
  - ❑ School Records
  - ❑ Corroborated by a relative/friend ❑ Not Available
- ❑ Symptoms are not better explained by another disorder (e.g. Schizophrenia, Mood Disorder, Anxiety Disorder, Substance Abuse, Dissociative Disorder, or Personality Disorder)
- ❑ The diagnosis has been verified using a standardized rating scale
  - ❑ Adult Self-Report Scale- V1.1
  - ❑ Wender Adult ADHD Rating Scale
  - ❑ Other:_____
- ❑ **THE PATIENT-SPECIFIC DSM SYMPTOMS, CRITERIA, PSYCHOLOGICAL EVALUATION, AND/OR STANDARDIZED RATING SCALE USED TO MAKE OR VERIFY THE DIAGNOSIS *MUST* BE SUBMITTED WITH THIS FORM FOR APPROVAL.**

*****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
REVISED/UPDATED: ~~7/29/2014; 8/4/2014; 8/6/14; 8/20/14; 9/15/2014; 10/21/2014; 10/30/2014; 3/19/2015; 4/10/2015; 5/27/2015; 7/16/2015; 8/11/2015; 12/27/2015; 4/21/2016; 10/20/2016; 12/12/2016;~~ **8/10/2017**;