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; **(Pharmacy) 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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested (select one below): Non-Preferred Central Nervous (CNS) Stimulants

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

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy**: ________________

Diagnosis: ______________________ **ICD Code, if applicable:** ________________

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

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; 6/25/2018;~~ **(Reformatted) 6/3/2019**