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 (*select one*):

❑ **Adzenys XR-ODT™** (amphetamine extended-release orally disintegrating tablets)	❑ **Dyanavel™ XR** (amphetamine extended-release oral suspension)

***DRUG INFORMATION:* Complete information below. If incomplete, authorization process will be delayed.**

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

- **Adzenys XR-ODT:** ***maximum dosage per day*** - 18.8 mg for 6 to 12 years of age; 12.5 mg for patients 13 to17 years.
- **Dyanavel™ XR: maximum dosage per day – 8ml/day (2.5mg);** ***daily doses above 20mg will not be authorized.***

***CLINICAL CRITERIA*: Check boxes below that apply or authorization process will be delayed.**

❑ Patient is ≥ 6 years of age.

❑ Has tried and failed therapy with:

- ❑ amphetamine-dextroamphetamine SR caps (generic Adderall XR®)

  AND

- ❑ Vyvanse®

  AND

- ❑ methylphenidate CR (generic Metadate CD®) **OR** ❑ methylphenidate SR (generic Ritalin LA®)

❑ ***If the member is over the age of 19, submit documentation of diagnosis (i.e. diagnosing prescriber, date of diagnosis, symptoms, patient specific criteria and standardized rating scales used to make diagnosis). A 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:** 2/8/2016
REVISED/UPDATED: ~~4/21/2016; 5/4/2016; 5/18/2016;~~ 12/16/2016; **8/12/2017**;