AvMed

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 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Non-Preferred Central Nervous System (CNS) Stimulants (For all ages)

- **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.**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- Will the member be discontinuing a previously prescribed central nervous system (CNS) stimulant medication if approved for requested medication?

  ❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

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

❑ **Adhansia XR®**	❑ **Adzenys XR-ODT®** ❑ **Adzenys ER® Suspension**	❑ **amphetamine sulfate** (Evekeo®)	❑ **Azstarys®**
❑ **Cotempla XR-ODT®**	❑ **Dyanavel® XR Suspension** ❑ **Dyanavel® XR Chewable Tablets**	❑ **Evekeo ODT®**	❑ **Jornay PM®**
❑ **methylphenidate ER** (Aptensio XR®)	❑ **methylphenidate TD Patch** (Daytrana®)	❑ **Mydayis®**	❑ **Quillichew® ER**
❑ **Quillivant XR®**	❑ **Xelstrym™** (dextroamphetamine)		

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member 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® IR/ER)
  - ❑ methylphenidate IR/ER (generic Ritalin®/Methylin®/Ritalin SR®/Ritalin LA®/Concerta®/ Metadate CD®/Metadate ER®
- ❑ Member must have tried and failed **30 days of therapy** with Vyvanse® (**NOT** required for amphetamine sulfate (Evekeo®) or Evekeo ODT® requests)
- ❑ If the member is **over the age of 18**, member **must** also meet diagnostic criteria. The prior authorization form "CNS Stimulants for Adults Age 19 and Above" can be downloaded from: **https://www.avmed.org/forms/provider/**

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****

***Approved by Pharmacy and Therapeutics Committee:** ~~2/15/2018; 9/15/2022;~~ **2/17/2023**
REVISED/UPDATED: ~~2/19/2018; 6/25/2018; (Reformatted) 6/3/2019; 8/13/2019; 12/7/2020; 9/10/2021, 11/8/2021' 11/22/2021; 11/7/2022; 03/03/2023;10/26/2023;~~ **7/01/2024**