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.**

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.**

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/ dextroamphetamine** (Adderall®)	❑ **amphetamine/ dextroamphetamine ER** (Adderall XR®)
❑ **amphetamine sulfate** (Evekeo®)	❑ **Azstarys®**	❑ **Cotempla XR/ODT®**	❑ **dexmethylphenidate** (Focalin®)
❑ **dexmethylphenidate ER** (Focalin XR®)	❑ **dextroamphetamine** (Dextrostat®)	❑ **dextroamphetamine** (ProCentra®)	❑ **dextroamphetamine** (Zenzedi®)
❑ **dextroamphetamine ER** (Dexedrine Spansule®)	❑ **Dyanavel® XR Suspension** ❑ **Dyanavel® XR Chewable Tablets**	❑ **Evekeo ODT®**	❑ **Jornay PM®**
❑ **methamphetamine** (Desoxyn®)	❑ **methylphenidate ER** (Aptensio XR®)	❑ **methylphenidate ER** (Concerta®)	❑ **methylphenidate TD Patch** (Daytrana®)
❑ **methylphenidate ER** (Metadate ER®/ Ritalin SR®)	❑ **methylphenidate** (Methylin®/Ritalin®)	❑ **methylphenidate LA** (Ritalin LA®)	❑ **methylphenidate CD** (Metadate CD®)
❑ **Mydayis®**	❑ **Quillichew® ER**	❑ **Quillivant XR®**	❑ **Vyvanse®**
❑ **Xelstrym™** (dextroamphetamine)			

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.**

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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.

Name of Diagnosing Prescriber: _____ **Date of Diagnosis:** _____

If the member 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.

- ❑ 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, patient interview, or psychological evaluation
  - ❑ Adult Self-Report Scale- V1.1
  - ❑ Wender Adult ADHD Rating Scale
  - ❑ Other: _____
  - ❑ Member Interview
  - ❑ Psychological Evaluation
- ❑ **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.**

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If requesting Brand or generic when applicable for **Adhansia XR®, Adzenys®, Aptensio XR®, Azstarys®, Cotempla XR ODT®, Daytrana®, Dyanavel® XR, Evekeo®/Evekeo ODT®, Jornay PM®, Mydayis®, Quillichew® ER, Quillivant® XR or Xelstrym™, BOTH of the following criteria MUST be met:**

- ❑ 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)

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 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:** ~~7/17/2014; 1/18/2018; 9/15/2022;~~ **2/16/2023**
REVISED/UPDATED: ~~12/12/2016; 8/10/2017; 3/20/2018; 6/25/2018; (Reformatted) 6/3/2019; 7/17/2019; 8/13/2019; 12/7/2020; 9/10/2021; 11/8/2021; 11/7/2022;03/02/2023 10/26/2023;~~ **7/01/2024**