AmeriHealth Caritas Iowa
Request for Prior Authorization

Central Nervous System (CNS) Stimulants and Atomoxetine

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Prior to requesting PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website at https://pmp.iowa.gov/IAPMPWebCenter/. Payment for CNS stimulants and atomoxetine will be considered under the following conditions: 1) Attention deficit Ddisorder (ADD) or attention deficit hyperactivity disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, Snap-IV). Symptoms must have been present before 12 years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms the patient continues to require medication to treat the symptoms of ADD/ADHD will be required for renewals or patients newly eligible that are established on medication to treat ADD/ADHD. 2) Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG). 3) Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.

Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

Requests for Vyvanse for binge eating disorder must be submitted on the binge eating disorder agents PA form.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred:

- ☐ Adzenys XR ODT
- ☐ Amphetamine salt combo
- ☐ Atomoxetine
- ☐ Daytrana
- ☐ Dexmethylphenidate Tabs
- ☐ Metadate CD
- ☐ Methylin Solution
- ☐ Methylphenidate IR Tabs
- ☐ Methylphenidate ER Capsules
- ☐ Methylphenidate ER tabs (18, 27, 36, 54mg)
- ☐ Modafinil
- ☐ Quillichew ER
- ☐ Quillivant XR
- ☐ Vyvanse

Non-Preferred:

- ☐ Adderall
- ☐ Adderall XR*
- ☐ Amphetamine ER*
- ☐ Aptensio XR*
- ☐ Armodafinil
- ☐ Concerta
- ☐ Desoxyn
- ☐ Dexedrine*
- ☐ Dexmethylphenidate
- ☐ Dexmethylphenidate ER*
- ☐ Dextroamphetamine ER Cap*
- ☐ Dyanavel XR
- ☐ Evekeo
- ☐ Focalin
- ☐ Focalin XR
- ☐ Methylin chew
- ☐ Methylphenidate ER Tabs (10mg and 20mg)*
- ☐ Nuvigil
- ☐ Procentra
- ☐ Provigil
- ☐ Ritalin
- ☐ Ritalin LA
- ☐ Ritalin SR*
- ☐ Strattera

Strength: Dosage Instructions: Quantity: Days Supply:

*If a non-preferred long-acting medication is requested, a trial with the preferred immediate release and extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Diagnosis

☐ Attention deficit disorder (ADD) ☐ Attention deficit hyperactivity disorder (ADHD)

Age of patient at onset of symptoms:

Date of most recent clinical visit confirming initial or continued diagnosis:

Rating scale used to determine diagnosis:

Documentation of clinically significant impairment in two or more **current** environments (social, academic, or occupational).

Current environment 1 and description:

Current environment 2 and description:

☐ Narcolepsy (please provide results from a recent ESS, MSLT, and PSG)

☐ Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS)

Have non-pharmacological treatments been tried? ☐ No ☐ Yes If yes, please indicate below:

☐ Weight loss ☐ Position therapy

☐ CPAP Date: Maximum titration? ☐ Yes ☐ No

☐ BiPAP Date: Maximum titration? ☐ Yes ☐ No

☐ Surgery Date:

Specifics:

Diagnosis confirmed by a sleep specialist? ☐ Yes ☐ No

☐ Other (specify):

Prescriber review of patient's controlled substances use on the Iowa PMP website:

☐ No ☐ Yes Date reviewed:

Please document prior psychostimulant trial(s) and failures(s) including drug name(s), strength, dose, exact date ranges, and failure reasons:

Other - Please provide all pertinent medication trial(s) relating to the diagnosis including drug name(s), strength, dose, and exact date ranges:

Reason for use of non-preferred drug requiring approval:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.