Updated: 12/2018
PARP Approved: 12/2018

Gateway Health
Prior Authorization Criteria
Stimulant Medications (ADHD and Narcolepsy)

All requests for Stimulant Medications for members **under the age of 4 or 21 years of age and older** require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Stimulant Medications Prior Authorization Criteria:

For all requests for Stimulant Medications all of the following criteria must be met:

- Member will be using the medication for a FDA-approved or medically accepted indication
- The prescribing provider confirms that the member's Prescription Monitoring Program (PMP) profile has been reviewed
- Member has been counseled on the potential adverse effects of stimulants, including the risk of serious cardiovascular and psychiatric side effects as well as misuse, abuse, and dependence
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

For members **21 years of age and older,** coverage may be provided with a diagnosis of **Attention Deficit Hyperactivity Disorder (ADHD)** and the following criteria is met:

- Documentation confirming the diagnosis of adult ADHD (*including evidence of inattention or hyperactive-impulsive symptoms before age 12*)
- Evidence of ongoing symptoms due to ADHD that cause significant impairment in social, academic, or occupational functioning
- Prescriber has ruled out any diagnoses or other potential medical confounders as the underlying reason for ongoing hyperactive-impulsive or inattentive symptoms (such as thyroid diseases, sleep disorders, inadequately treated depression, bipolar disorder, anxiety, post-traumatic stress disorder, substance abuse, or other personality disorders)

For members **21 years of age and older,** coverage may be provided with a diagnosis of **Narcolepsy** and the following criteria is met:

- A diagnosis of narcolepsy was confirmed through documentation of excessive daytime sleepiness (≥ 3 months) plus one or more of the following:
    - Cataplexy
    - CSF hypocretin deficiency (one-third less than normal or <110 pg/mL)
    - Polysomnogram sleep study test with REM sleep latency ≤ 15 minutes
    - Multiple sleep latency testing with a mean sleep latency ≤ 8 minutes with ≥ 2 sleep onset REM sleep periods

For members **under the age of 4**, coverage may be provided with a diagnosis of **Brain Injury, Attention Deficit Hyperactivity Disorder, Attention Deficit Disorder, and/or Autism** and the following criteria is met:

- If medication is being used for Attention Deficit Hyperactivity Disorder, or Attention Deficit Disorder, member must have had an adequate trial of parent training or teacher administered behavioral therapy and has persistent moderate to severe dysfunction as defined by :
    - Symptoms that have persisted for at least 9 months.
    - Dysfunction that is manifested in both the home and other setting such as preschool or child care.
- Medication is being prescribed by or in consultation with a pediatric neurologist, child psychiatrist, and or child development pediatrician.
- Member must have charted documented evidence of a comprehensive evaluation by the provider.

Initial Duration of Approval: 12 months.

Reauthorization Criteria

- Attestation from the prescriber that the member's PMP profile has been reviewed
- The provider submits documentation showing treatment with stimulant therapy has provided improvement in the patient's condition

Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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STIMULANT MEDICATIONS
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

Has the patient's Prescription Drug Monitoring Program (PDMP) profile been reviewed?
☐ Yes ☐ No Date reviewed by provider:

Has the member been counseled on the potential adverse effects of stimulants, including the risk of serious cardiovascular and psychiatric side effects as well as misuse, abuse, and dependence? ☐ Yes ☐ No

INITIAL AUTHORIZATION

For a diagnosis of ADHD in adults 21 years of age and older:

- Is documentation attached to this request that confirms the diagnosis? ☐ Yes ☐ No
- Did the patient have inattentive or hyperactive-impulsive symptoms present prior to age 12? ☐Yes ☐ No
- Have other diagnoses been ruled out as the underlying reason for ongoing hyperactive-impulsive or inattentive symptoms (including but not limited to thyroid diseases, sleep disorders, inadequately treated depression, bipolar disorder,anxiety, post-traumatic stress disorder, substance abuse, or other personality disorders)? ☐ Yes ☐ No
- Please provide a description or attach chart documentation of ongoing symptoms due to ADHD that cause clinically significant impairment (social, academic, and/or occupational):_____
_____

For a diagnosis of Narcolepsy:

- Is documentation that confirms the diagnosis attached to this request? ☐ Yes ☐ No

Document must contain evidence of excessive daytime sleepiness (≥ 3 months) and one or more of the following:

- Cataplexy
- CSF hypocretin deficiency (one third less than normal or ≤110 pg/mL)
- Polysomnogram sleep study test with REM sleep latency ≤ 15 minutes
- Multiple sleep latency testing with a mean sleep latency ≤ 8 minutes with ≥ 2 sleep onset REM sleep periods

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STIMULANT MEDICATIONS
PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2

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MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

For a diagnosis of ADHD in children under 4 years of age:
Has the member tried and failed parent training or teacher administered behavioral therapy? ☐ Yes ☐ No
If Yes, please provide member's duration of symptoms (in months): _____
In what settings have the member's dysfunction manifested (home, school, etc)? _____
If member is under the age of 4, has a pediatric neurologist, child psychiatrist, and or child development pediatrician been consulted? ☐ Yes ☐ No

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date