HIGHMARK HEALTH OPTIONS

Updated: 09/2024
DMMA Approved: 09/2024

**Request for Prior Authorization for Stimulant Medications**
**Website Form – www.highmarkhealthoptions.com**
**Submit request via: Fax - 1-855-476-4158**

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.

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 is not receiving concurrent treatment with a CNS depressant (benzodiazepine or a non-benzodiazepine sedative hypnotic medication). If a member is receiving concurrent treatment with a CNS depressant, a transition plan must be submitted with this request showing removal of concurrent CNS depressant therapy
- 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 non-preferred agents, must have a therapeutic failure, contraindication, or intolerance to the preferred agent(s) approved or medically accepted for the member's diagnosis

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 documented evidence of a comprehensive evaluation by the provider.

**Initial Duration of Approval:** 12 months. In situations where the member is on concurrent CNS depressant therapy (a benzodiazepine or a non-benzodiazepine sedative hypnotic medication) and a transition plan is provided, authorization length will be for three (3) months

**Reauthorization criteria**

- Attestation from the prescriber that the member's PMP profile has been reviewed
- Member is not receiving concurrent treatment with a CNS depressant (a benzodiazepine or a non-benzodiazepine sedative hypnotic medication). If a member is receiving concurrent treatment with a CNS depressant, a transition plan must be submitted with this request showing removal of concurrent CNS depressant therapy. Requests for members that are maintaining continued concurrent CNS depressant therapy and not transitioning off will be denied
- 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 with a diagnosis of binge eating disorder and all of the following criteria must be met: (**Vyvanse (lisdexamfetamine) only**)

- Medication must be prescribed by, or in consultation with a psychiatrist or psychiatric nurse practitioner.

- Member must meet DSM-V criteria for Binge Eating Disorder (BED) including ALL of the following:
    - Recurrent episodes of binge eating characterized by BOTH eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances; AND a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
    - The binge eating episodes are associated with THREE or MORE of the following:
        - Eating much more rapidly than normal.
        - Eating until feeling uncomfortable full
        - Eating large amounts of food when not feeling physically hungry
        - Eating alone because of feeling embarrassed by how much one is eating
        - Feeling disgusted with oneself, depressed, or very guilty afterwards.
    - Marked distress regarding binge eating is present
    - Absence of compensatory behaviors such as purging or excessive exercise.
- BED is classified as moderate to severe (moderate: 4-7 binge eating episodes per week; severe: 8-13 binge eating episodes per week) with the number of binge episodes per week documented.
- The prescribed medication is not being used for weight loss or to treat obesity.
- There must be documentation that non-pharmacologic therapies (such as cognitive-behavioral therapy and/or interpersonal therapy with a clinician) have been utilized within the past 6 months.
- Attestation the member will continue cognitive behavioral therapy or interpersonal therapy with a clinician while on pharmacologic agents.
- **Initial Duration of Approval:** 4 months
- **Reauthorization Criteria**
    - Attestation from the prescriber that the member's PMP profile has been reviewed
    - Member is not receiving concurrent treatment with a CNS depressant (a benzodiazepine or a non-benzodiazepine sedative hypnotic medication). If a member is receiving concurrent treatment with a CNS depressant, a transition plan must be submitted with this request showing removal of concurrent CNS depressant therapy. Requests for members that are maintaining continued concurrent CNS depressant therapy and not transitioning off will be denied
    - There must be documentation submitted that shows an improvement from baseline in the number of binge days per week.
    - The member continues to receive cognitive behavioral therapy or interpersonal therapy with a clinician while on pharmacologic agents.
    - The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

  **Reauthorization Duration of Approval:** 6 months, for prescriber to observe continued improvement

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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product 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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
**PHONE**: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

## PROVIDER INFORMATION

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

## MEMBER INFORMATION

| | | |
|---|---|---|
| Member Name: | DOB: | |
| Member ID: | Member weight: | Height: |

## REQUESTED DRUG INFORMATION

| | | |
|---|---|---|
| Medication: | Strength: | |
| Directions: | Quantity: | Refills: |
| Is the member currently receiving requested medication? ☐ Yes ☐ No | Date Medication Initiated: | |

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

## 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 Delaware Prescription Monitoring Program (PMP) profile been reviewed?
☐ Yes ☐ No Date reviewed by provider:

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)? _____

Is the member currently taking a CNS depressant (a benzodiazepine or non-benzodiazepine sedative hypnotic)? ☐Yes ☐ No
If **yes,** is there a transition plan to discontinue CNS depressant therapy? ☐ Yes ☐ No
If **no**, please provide clinical rationale for continuation while on CNS stimulant: _____
_____

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

If member is under the age of 4, has a pediatric neurologist, child psychiatrist, and or child development pediatrician been consulted? ☐ Yes ☐ No

## CURRENT or PREVIOUS THERAPY

| Medication Name | Strength/ Frequency | Dates of Therapy | Status (Discontinued & Why/Current) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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## STIMULANT MEDICATIONS
## PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 3

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### MEMBER INFORMATION

| | | |
|---|---|---|
| Member Name: | DOB: | |
| Member ID: | Member weight: | Height: |

### MEDICAL HISTORY (Complete for ALL requests)

**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

**For a diagnosis of ADHD:**

- 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
- Please provide a description or attach chart documentation of ongoing symptoms due to ADHD that cause clinically significant impairment (social, academic, and/or occupational):_____

_____

_____

_____

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

**For a diagnosis of binge eating disorder:**

Is the member experiencing recurrent episodes of binge eating characterized by:

1. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances? ☐ Yes ☐ No
2. A sense of lack of control over eating during the episode (ie. a feeling that one cannot stop eating or control what or how much one is eating)? ☐ Yes ☐ No

Is there marked distress regarding binge eating? ☐ Yes ☐ No

Are there any compensatory behaviors such as purging or excessive exercise? ☐ Yes ☐ No

How many binge eating episodes occur per week? ☐ 0 to 3 ☐ 4 to 7 ☐ 8 or more

Which of the following apply to the binge eating episodes:

- ☐ Eating much more rapidly than normal
- ☐ Eating until feeling uncomfortably full
- ☐ Eating large amounts of food when not feeling physically hungry
- ☐ Eating alone because of feeling embarrassed by how much one is eating
- ☐ Feeling disgusted with oneself, depressed, or very guilty afterwards

Is the medication being used for weight loss or to treat obesity? ☐ Yes ☐ No

Have non-pharmacologic therapies (e.g. cognitive behavioral therapy, interpersonal therapy) been utilized in the past 6 months?
☐ Yes ☐ No

Will the member continue cognitive behavioral therapy or interpersonal therapy with a clinician while on pharmacologic agents?
☐ Yes ☐ No

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**STIMULANT MEDICATION**
**PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 3 OF 3**

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**MEMBER INFORMATION**

| | | |
|---|---|---|
| Member Name: | DOB: | |
| Member ID: | Member weight: | Height: |

**REAUTHORIZATION**

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

Has the PMP profile been reviewed? ☐ Yes ☐ No

Is the member receiving concurrent treatment with a CNS depressant (benzodiazepine or sedative hypnotic medication?
☐ Yes *(must provide transition plan for removal of concurrent CNS depressant)* ☐ No

**For binge eating disorder:**
Is the member receiving cognitive behavioral therapy or interpersonal therapy with a clinician while on pharmacologic agents?
☐ Yes ☐ No
Has there been a decrease since baseline in the number of binge eating episodes per week?
☐ Yes ☐ No

**SUPPORTING INFORMATION or CLINICAL RATIONALE**

| **Prescribing Provider Signature** | Date |
|---|---|
| | |