Updated: 08/2019
DMMA Approved: 08/2019

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

All requests for **Stimulants 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.

Stimulants 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 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 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. 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 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.

HIGHMARK. Delaware HEALTH OPTIONS

Updated: 08/2019
DMMA Approved: 08/2019

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) 325-6253 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:
Health Options 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:

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

Updated: 08/2019
DMMA Approved: 08/2019

Stimulant Medications
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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) 325-6253 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

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

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date