

ANTIHYPERKINESIS AGENTS PA SUMMARY

PREFERRED	All Generic Products, Dextroamphetamine Sulfate, Amphetamine Salt Combo, Methamphetamine, Methylphenidate HCL, Methylphenidate ER, Adderall XR, Concerta, Dextrostat, Focalin, Focalin XR, Metadate CD, Metadate ER, Methylin, Methylin ER, Methylin Chewable Tablets, Methylin Oral Solution, Ritalin LA, Vyvanse
NON-PREFERRED	Adderall, Daytrana, Desoxyn, Dexedrine caps/tabs, Liquadd, Provigil, Strattera, Procentra, Ritalin, Ritalin SR, Branded versions of generic equivalents

LENGTH OF AUTHORIZATION: 1 YEAR

NOTE: *All preferred and non-preferred agents will be subject to the DCH clinical PA criteria review for members 21 years of age and older. Daytrana, Desoxyn, Liquadd, Procentra, Provigil, and Strattera are non-preferred agents that require prior authorization for members of all ages.*

PA CRITERIA:

For all agents for members 21 years of age and older (except Daytrana, Desoxyn, Liquadd, Procentra, Provigil, and Strattera)

- ❖ Approvable diagnoses are as follows:
 - Narcolepsy
 - Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)

For Desoxyn

- ❖ Approvable for diagnoses of narcolepsy, ADD or ADHD, or minimal brain dysfunction. Member must have initiated therapy with at least 1 agent in at least 2 of the following groups in the past 12 months: 1. Adderall XR, amphetamine salt combinations, Vyvanse 2. Concerta, methylphenidate HCL, Metadate CD, Methylin, Methylin ER, Metadate ER, methylphenidate ER, Ritalin LA 3. Focalin , Focalin XR 4. Dextrostat, dextroamphetamine

OR

- ❖ Submit documentation of allergies, contraindications, drug-drug interactions, or show a history of intolerable side effects to at least 1 medication in at least 2 of the groups listed above.

For Provigil

- ❖ Diagnosis of narcolepsy, shift work sleep disorder, and obstructive sleep apnea/hypo-apnea syndrome (with CPAP machine use) are approvable indications for Provigil. Otherwise, patient must meet Desoxyn criteria listed above.

For Strattera

- ❖ Strattera requests are approvable for diagnoses of ADD or ADHD when the member has a substance abuse disorder or has a family history of substance abuse. Alternatively, patients with ADD or ADHD must have previously initiated therapy with at least 1 agent in at least 2 of the drug groups listed in the Desoxyn criteria above.

For Daytrana

- ❖ Member must be aged 6-12 years with a diagnosis of ADD or ADHD
AND
- ❖ Member must be unable to swallow oral dosage forms of medication
OR
- ❖ Member must have tried and failed at least 1 agent in drug group 2 or 3 and 1 agent in group 1 or 4 in the Desoxyn criteria above.

For Liquadd or Procentra

- ❖ Member must have a diagnosis of ADD or ADHD and be unable to swallow solid oral dosage forms of medication (ex. tablets, capsules)

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827.**

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.ghp.georgia.gov, select the Provider Information tab, click on “view full text” in the Pharmacy Services box, click on “Prior Approval Process” in the list on the left.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to www.ghp.georgia.gov, select Provider Information, click on “view full list” in the Medicaid Provider Manuals box then select Pharmacy Services from the list shown.