

ANTIHYPERKINESIS AGENTS PA SUMMARY

PREFERRED	Amphetamine-Dextroamphetamine, Amphetamine Salt combo; Concerta, Dextroamphetamine Sulfate, Focalin/XR, Metadate CD/ER, Methylin Chew Tabs, Methylin/ER, Methylin Oral Solution, Methylphenidate/SR/ER, Vyvanse
NON-PREFERRED	Branded version of generic equivalents, Adderall, Adderall XR, Amphetamine Salt Combo Extended-Release, Daytrana, Desoxyn, Dexedrine caps/tabs, Dexmethylphenidate, Intuniv, Kapvay, Methamphetamine, Nuvigil, Procentra, Provigil, Strattera, Ritalin/LA/SR

LENGTH OF AUTHORIZATION: Varies depending upon medication

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. Adderall XR (brand or generic), Daytrana, Desoxyn (brand or generic), Dexmethylphenidate, Intuniv, Kapvay, Methylphenidate oral solution (generic), Nuvigil, Provigil, Procentra, Ritalin LA, and Strattera are non-preferred agents that require prior authorization for members of all ages. If a PA is approved for Adderall XR or Desoxyn, the approval will be for the brand product.*

PA CRITERIA:

For all agents for members 21 years of age and older (except Adderall XR [brand or generic], Daytrana, Desoxyn [brand or generic], Dexmethylphenidate, Intuniv, Kapvay, Methylphenidate oral solution [generic], Nuvigil, Provigil, Procentra, Ritalin LA, and Strattera)

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

For Desoxyn (brand or generic), Adderall XR (brand or generic), and Ritalin LA

- ❖ Member must have initiated therapy with at least 1 agent in at least 2 of the following groups in the past 12 months: 1. amphetamine salt combinations, Vyvanse 2. Concerta, methylphenidate HCL, Metadate CD, Methylin, Methylin ER, Metadate ER, methylphenidate ER 3. Focalin , Focalin XR 4. 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 Intuniv and Kapvay

- ❖ Requests are approvable for members aged 6 to 17 years old. Members must have a diagnosis of ADD or ADHD and a personal or family history of substance abuse. Alternatively, patients 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 Provigil and Nuvigil

- ❖ Diagnosis of narcolepsy, shift work sleep disorder, and obstructive sleep apnea/hypo-apnea syndrome (with CPAP machine use) are approvable indications. Patients with narcolepsy must be on CPAP treatment. Otherwise, patient must meet Desoxyn criteria listed above. Provigil is approvable under the above conditions for members 16 years of age or older. Nuvigil is approvable under the above conditions for members 17 years of age or older.

For Strattera

- ❖ Strattera requests are approvable for diagnoses of ADD or ADHD for members with a personal or family history of substance abuse. Alternatively, patients 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 Procentra

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

For Generic Dexmethylphenidate

- ❖ Submit a written letter of medical necessity stating the reason(s) the preferred product, brand name Focalin, is not appropriate for the member.

For Generic Methylphenidate oral solution

- ❖ Submit a written letter of medical necessity stating the reason(s) the preferred product, brand name Methylin oral solution, is not appropriate for the member.

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.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

Quantity Level Limitations:

- ❖ For online access to the current Quantity Level Limits please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.