

CRITERIA FOR PRIOR AUTHORIZATION

Use of Stimulant Medications in Adults Ages 18 and Older

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:

- Amphetamine (Dyanavel XR®)
- Amphetamine (Adzenys XR®)
- Amphetamine/Dextroamphetamine (Adderall®)
- Amphetamine/Dextroamphetamine (Adderall XR®)
- Dexmethylphenidate HCl (Focalin®)
- Dexmethylphenidate HCl ER (Focalin XR®)
- Dextroamphetamine Sulfate (Zenzedi®)
- Dextroamphetamine Sulfate (Dexedrine®)
- Dextroamphetamine Sulfate (DextroStat®)
- Dextroamphetamine Sulfate (ProCentra®)
- Lisdexamphetamine Dimesylate (Vyvanse®)
- Methamphetamine HCl (Desoxyn®)
- Methylphenidate HCl (Aptensio XR®)
- Methylphenidate HCl (Concerta®)
- Methylphenidate HCl (Metadate CD®)
- Methylphenidate HCl (Metadate ER®)
- Methylphenidate HCl (Methylin®)
- Methylphenidate HCl (Quillichew ER)
- Methylphenidate HCl (Quillivant XR®)
- Methylphenidate HCl (Ritalin®)
- Methylphenidate HCl (Ritalin LA®)
- Methylphenidate Transdermal (Daytrana®)

*non-stimulant ADHD medications are not included in this criteria

CRITERIA FOR PRIOR AUTHORIZATION FOR STIMULANT MEDICATIONS PRESCRIBED TO ADULTS AGES 18 OR OLDER:

- One of the following criteria must be met:
 - Patient must have a documented diagnosis within the previous 365 days of adult ADHD, binge eating disorder, hypersomnolence, narcolepsy, depression in accordance with DSM-V or cancer related fatigue.
 - OR
 - Prescription must be written by a psychiatrist.
- Patients with a documented substance abuse diagnosis within the previous 365 days will require a peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval

LENGTH OF APPROVAL: 12 months

PA Criteria

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

DATE