

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Stimulants and Related Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Stimulants and Related Agents that meet the following conditions must be prior authorized.

1. A prescription for a non-preferred Stimulant and Related Agent. See Preferred Drug List (PDL) for the list of preferred Stimulants and Related Agents at:
www.providersynergies.com/services/documents/PAM_PDL.pdf
2. A prescription for a preferred Stimulant and Related Agent with a prescribed quantity that exceeds the quantity limit. See Quantity Limits for the list of drugs with quantity limits at:
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>
3. A prescription for a preferred or a non-preferred Stimulant and Related Agent for a recipient under 4 years of age
4. A prescription for a Stimulant and Related Agent when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs in the Department's Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).
EXCEPTION: Intuniv, Nuvigil and Provigil
5. A prescription for a preferred or non-preferred Stimulant and Related Agent for a recipient 18 years of age or older.
EXCEPTION: Provigil and Nuvigil

GRANDFATHER PROVISION – The Department will grandfather prescriptions for non-preferred Stimulants and Related Agents within quantity limits when the PROMISe Point-Of-Sale On-Line Claims Adjudication System verifies that the recipient has a record of a paid claim for a non-preferred Stimulant and Related Agent within the past 90 days from the date of service of the new claim. If the recipient has a record of a paid claim for a non-preferred Stimulant and Related Agent, a prescription or a refill for the same Stimulant and Related Agent within the quantity limits will be automatically approved.

Grandfathering does not apply to prescriptions for either a preferred or non-preferred Stimulant and Related Agent when prescribed for a recipient under 4 years of age or 18 years of age or older, or that are considered to be duplicate therapy.

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Stimulant and Related Agent, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For Provigil (modafinil) and Nuvigil (armodafinil) – Whether the recipient:
 - a. Is not receiving concurrent treatment with sedative hypnotics

AND

- b. Has a diagnosis of:
 - i. Narcolepsy confirmed by an overnight polysomnogram (PSG) followed by a:
 - a) A multiple sleep latency test (MSLT)

OR

- ii. Obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by a Respiratory Disturbance Index (RDI) of greater than 5 per hour

AND

Therapeutic failure of Continuous Positive Airway Pressure (CPAP) to resolve excessive daytime sleepiness (documented by either Epworth Sleepiness Scale greater than 10 or Multiple Sleep Latency Test [MSLT] less than 6 minutes)

OR

- c. Shift work sleep disorder (SWSD) as documented by:
 - i. Recipient's recurring work schedule for one (1) month or longer

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

AND

- ii. Shift work which results in sleepiness on the job or insomnia at home that interferes with activities of daily living

OR

- d. Has a diagnosis of multiple sclerosis and fatigue associated with multiple sclerosis **AND**

- i. Is receiving treatment for multiple sclerosis

AND

- ii. Tried and failed methylphenidate at maximum dosing

AND

- 2. For Nuvigil - Whether the recipient has a history of therapeutic failure, contraindication or intolerance to Provigil
- 3. For Intuniv, whether the recipient has a documented history of therapeutic failure of Guanfacine
- 4. For all other non-preferred Stimulants and Related Agents, whether the recipient has a history of therapeutic failure of the preferred Stimulants and Related Agents.
- 5. For children under 4 years of age - Whether the MA recipient
 - a. Has a diagnosis of:
 - i. Attention Deficit Hyperactivity Disorder (ADHD), **OR**
 - ii. Attention Deficit Disorder (ADD), **OR**
 - iii. Brain injury, **OR**
 - iv. Autism

AND

- b. Is being prescribed the medication by an appropriate specialist or in consultation with a:
 - i. Pediatric Neurologist, **OR**
 - ii. Child and Adolescent Psychiatrist. **OR**

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

iii. Child Development Pediatrician

AND

c. Has chart documented evidence of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above

6. For therapeutic duplication, whether:

a. The recipient is being titrated to, or tapered from, a drug in the same class

OR

b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested

7. For a preferred or non-preferred Stimulant and Related Agent for recipients 18 years of age and older:

a. For a Stimulant and Related Agent, whether the recipient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) as documented by a history consistent with the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria

OR

b. For a Stimulant Agent, whether the recipient has a diagnosis of narcolepsy as confirmed by:

i. A sleep study followed by a multiple sleep latency test

AND

ii. A history consistent with narcolepsy

AND

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

c. For a Stimulant Agent for a recipient with a history of ADHD or narcolepsy and co-morbid substance dependency, abuse or diversion, whether the recipient:

i. Is enrolled and actively participating in a substance dependency treatment program

AND

ii. Demonstrates compliance with the substance dependency treatment program as documented by a recent urine drug screen that tests negative for benzodiazepines, opiates and illicit drugs

OR

iii. Has a documented history of recovery and a recent negative urine drug screen for benzodiazepines, opiates and illicit drugs

OR

8. Whether the recipient does not meet the clinical review guidelines listed above, but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

C. Automated Prior Authorization Approvals

Prior authorization of a prescription for a non-preferred Stimulant and Related Agent in a quantity that does not exceed the quantity limit will be automatically approved when the PROMISE Point-of-Sale On-Line Claims Adjudication System verifies a record of paid claim(s) within 180 days prior to the date of service that documents that the guidelines to determine medical necessity listed in Section B. have been met.

Automated prior authorization approvals do not apply to the following:

1. A prescription for a preferred or non-preferred Stimulant and Related Agent with a prescribed quantity that exceeds the quantity limit
2. A prescription for a preferred or a non-preferred Stimulant and Related Agent for a recipient under 4 years of age

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

3. Therapeutic duplication
4. A prescription for a preferred or non-preferred Stimulant and Related Agent for a recipient 18 years of age or older

D. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for a Stimulant and Related Agent. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

All requests for prior authorization of a prescription for a Stimulant and Related Agent for a MA recipient under 4 years of age will be automatically forwarded to a physician reviewer (a psychiatrist) for a medical necessity determination. The physician reviewer (a psychiatrist) will consider the guidelines in Section B. above and will approve the request when, in the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the recipient.

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MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

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