

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:  
[http://www.providersynergies.com/services/documents/PAM\\_PDL\\_20100223.pdf](http://www.providersynergies.com/services/documents/PAM_PDL_20100223.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/ucmprd/groups/webcontent/documents/document/s\\_002077.pdf](http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s_002077.pdf)
3. A prescription for a preferred or a non-preferred Stimulant and Related Agent for a recipient under 4 years of age.

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.

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 – Whether the recipient has a diagnosis of:
  - a. Narcolepsy documented by:

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- i. A multi-latency sleep test

**OR**

- ii. A clinical interview if the prescriber is an American Board of Medical Specialties (ABMS) certified psychiatrist/sleep specialist

**OR**

- b. Obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by a Respiratory Disturbance of >5

**AND**

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

**OR**

- c. Shift work sleep disorder (SWSD) as documented by:
    - i. Recipient's recurring work schedule for one (1) month or longer
- OR**
- ii. Shift work which results in sleepiness on the job or insomnia at home which interferes with daily living

**OR**

- d. Multiple sclerosis and is receiving treatment for fatigue associated with multiple sclerosis
- 2. For Intuniv, whether the recipient has a documented history of therapeutic failure of Guanfacine
  - 3. 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.
  - 4. For children under 4 years of age - Whether the MA recipient

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- 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
  - 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

**OR**

- 5. 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.

D. Clinical Review Process

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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.

References:

1. Greenhill LL. The use of Psychotropic Medication in Preschoolers: Indications, Safety and Efficacy. *Can J Psychiatry* 1998; 43:576-581
1. 2. Diller LH. Lessons from Three Year Olds. *Developmental and Behavioral Pediatrics*. 2002; 23:S10-S12
2. American Academy of Pediatrics. Clinical Practice Guideline: Treatment of the School-Aged Child with Attention-Deficit/ Hyperactivity Disorder. *Pediatrics* 2001; 108:1033-1044
3. American Academy of Child and Adolescent Psychiatry: Practice Parameter for the Assessment and Treatment of Children and Adolescents with attention-Deficit/Hyperactivity Disorder. 2007
4. Walter, H, Bukstein, O. "AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/ Hyperactivity Disorder" *Journal of the American Academy of Child and Adolescent Psychiatry*. 2007; 46: 894-921.
5. Scahill L, Chappell PB, Kim YS et al. "A placebo-controlled study of guanfacine in the treatment of children with tic disorders and attention deficit hyperactivity disorder" *American Journal of Psychiatry*. 2001; 158: 1067-1074.
6. Intuniv™ Package Insert, Shire Pharmaceuticals August 2009.