Health Partners Plans

**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Stimulants and Related Agents

**Phone: 215-991-4300 Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Patient Name: | Prescriber Name: | |
| HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Patient Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |
| *HPP's maximum approval time is 12 months but may be less depending on the drug.* | | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. Is the patient less than 4 years of age?
[If no, then skip to question 5.]

☐ Yes ☐ No

Q2. Does the patient have ANY of the following diagnoses: A) attention-deficit hyperactivity disorder (ADHD), B) attention deficit disorder (ADD), C) brain injury, D) autism?

☐ Yes ☐ No

Q3. Is the requested drug being prescribed by or in consultation with ONE of the following: A) pediatric neurologist, B) child and adolescent psychiatrist, C) child development pediatrician?

☐ Yes ☐ No

Q4. Does the patient have chart documented evidence of a comprehensive evaluation by or in consultation with ONE of the following: A) pediatric neurologist, B) child and adolescent psychiatrist, C) child development pediatrician?

☐ Yes ☐ No

Q5. Is this a request for modafinil (Provigil) or armodafinil (Nuvigil)?
[If no, then skip to question 22.]

☐ Yes ☐ No

Q6. Is the patient receiving concomitant treatment with sedative hypnotics?

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of narcolepsy confirmed by an overnight polysomnogram (PSG) followed by a

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multiple sleep latency test (MSLT)?
[If yes, then skip to question 20.]

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS)?
[If no, then skip to question 13.]

☐ Yes ☐ No

Q9. Is the patient's diagnosis documented by an overnight polysomnogram (PSG) with a respiratory disturbance index of greater than 5 per hour?

☐ Yes ☐ No

Q10. Does the patient have documentation of therapeutic failure of continuous positive airway pressure (CPAP) to resolve excessive daytime sleepiness (documented by either Epworth Sleepiness Scale greater than 10 or MSLT less than 6 minutes) with documented compliance to CPAP treatment?
[If yes, then skip to question 20.]

☐ Yes ☐ No

Q11. Does the patient have a medical reason continuous positive airway pressure (CPAP) cannot be used?

☐ Yes ☐ No

Q12. Does the patient have documentation of a therapeutic failure of an oral appliance for obstructive sleep apnea/hypopnea syndrome (OSAHS)?
[If yes, then skip to question 20.]

☐ Yes ☐ No

Q13. Does the patient have a diagnosis of shift work sleep disorder?
[If no, then skip to question 15.]

☐ Yes ☐ No

Q14. Is the patient's diagnosis documented by BOTH of the following: A) the patient's recurring work schedule for one (1) month or longer, B) shift work that results in sleepiness on the job or insomnia at home that interferes with activities of daily living?
[If yes, then skip to question 20.]

☐ Yes ☐ No

Q15. Does the patient have the diagnosis of multiple sclerosis-related fatigue?
[If no, then skip to question 19.]

☐ Yes ☐ No

Q16. Is the patient receiving treatment for multiple sclerosis?

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[If yes, then skip to question 18.]

☐ Yes ☐ No

Q17. Do the patient's medical records document the rationale for not receiving treatment for multiple sclerosis?

☐ Yes ☐ No

Q18. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of methylphenidate at maximally tolerated doses?
[If yes, then skip to question 20.]

☐ Yes ☐ No

Q19. Does the patient have a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medially accepted indication?

☐ Yes ☐ No

Q20. Is this a request for a preferred stimulant and related agent drug containing armodafinil or modafinil?
[If yes, then no further questions.]

☐ Yes ☐ No

Q21. Does the patient have a documented therapeutic failure, contraindication to, or intolerance of the preferred stimulant and related agent drugs containing armodafinil or modafinil?

☐ Yes ☐ No

Q22. Is the patient 18 years of age or older?
[If no, then skip to question 42.]

☐ Yes ☐ No

Q23. Is this a request for lisdexamfetamine (Vyvanse)?
[If no, then skip to question 31.]

☐ Yes ☐ No

Q24. Does the patient have a diagnosis of moderate to severe binge eating disorder?
[If no, then skip to question 31.]

☐ Yes ☐ No

Q25. Is this a request for a renewal of authorization?
[If no, then skip to question 27.]

☐ Yes ☐ No

Q26. Has the patient experienced a reduction in binge eating?

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☐ Yes ☐ No

Q27. Is the patient's diagnosis documented by a history that is consistent with the current Diagnostic and Statistical Manual (DSM) criteria?

☐ Yes ☐ No

Q28. Does the patient have a documentation of a referral for cognitive behavioral therapy or other psychotherapy?

☐ Yes ☐ No

Q29. Does the patient have a concurrent diagnosis of attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)?
[If yes, then skip to question 37.]

☐ Yes ☐ No

Q30. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of selective serotonin reuptake inhibitors (SSRIs) OR topiramate?
[If yes, then skip to question 37.]

☐ Yes ☐ No

Q31. Does the patient have a diagnosis of attention-deficit hyperactivity disorder (ADHD)?

☐ Yes ☐ No

Q32. Is the patient's diagnosis documented by a history consistent with the current Diagnostic and Statistical Manual (DSM) criteria?

☐ Yes ☐ No

Q33. Is the requested drug being prescribed for a medically accepted indication?

☐ Yes ☐ No

Q34. Is this a request for a stimulant agent?
[If no, then skip to question 42.]

☐ Yes ☐ No

Q35. Is the requested drug being prescribed for narcolepsy?

☐ Yes ☐ No

Q36. Is the patient's diagnosis confirmed by an overnight polysomnogram (PSG) followed by a mean sleep latency test (MSLT)?

☐ Yes ☐ No

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Q37. Has the patient been assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescriber?

☐ Yes ☐ No

Q38. Is there documentation that the patient has been educated on the potential adverse effects of stimulants, including the risk for misuse, abuse, and addiction?

☐ Yes ☐ No

Q39. Is there documentation that the prescriber or prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the patient's controlled substance prescription history?

☐ Yes ☐ No

Q40. Does the patient have a history of comorbid substance dependency, abuse, or diversion?
[If no, then skip to question 42.]

☐ Yes ☐ No

Q41. Does the patient have results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, tramadol, and carisoprodol) that is consistent with prescribed controlled substances?

☐ Yes ☐ No

Q42. Is this a request for guanfacine extended-release (Intuniv)?

☐ Yes ☐ No

Q43. Is this a request for a stimulant and related agent drug when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q44. Is the patient being titrated to or tapered from a drug in the same class?

☐ Yes ☐ No

Q45. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q46. Is this a request for a preferred stimulant or related agent drug?

☐ Yes ☐ No

Q47. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of a preferred stimulant and related agent drug?

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| | |
|---|---|
| ☐ Yes | ☐ No |
| Q48. Does the patient have a current history (within the past 90 days) of being prescribed the same requested non-preferred stimulant and related agent drug? | |
| ☐ Yes | ☐ No |
| Q49. Additional Information: | |

Prescriber Signature _____ Date _____

*Updated for 2020*